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ABSTRACT

Homelessness is growing among the elderly as it is among every other age cohort in America, but the elderly appear to be underrepresented. This underrepresentation is puzzling, since the elderly appear to have unique vulnerabilities to homelessness. This study explored the connection between the growing shortage of low rent housing, the unique housing related problems of the elderly, and homelessness itself. A sample of seniors who had experienced serious housing problems was identified from persons who had been served by the Chicago Department of Human Services Emergency Services. Two "housing risk" samples (N=91) were identified: those who had needed temporary housing and those who had lived in deplorable conditions. These at-risk persons were compared with similarly aged low-income residents of Single Rooms Occupancy units throughout the city who had not necessarily experienced housing emergencies. The results indicated that: (1) shelter use by the elderly was usually very short-term; (2) a significant proportion of the elderly were vulnerable to loss of their homes; (3) factors that precipitate the loss of and incapacity to manage their homes included living alone and lacking social supports, diminished mental functioning, and very low income; and (4) there was a shrinking supply of low-income housing and scarcity of supported living environments. These findings suggest a need for more innovative and intensive outreach and service delivery to elderly persons before their housing condition or the effects of various losses force them to lose their residence also. (ABL)

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RELOCATION, RESIDENCE & RISK:
A STUDY OF HOUSING RISKS AND THE CAUSES OF HOMELESSNESS AMONG THE URBAN ELDERLY

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AMONG THE URBAN ELDERLY

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EXECUTIVE SUMMARY

The Housing Problems of the Elderly

Homelessness is growing among the elderly as it is among every other age cohort in America, but the elderly appear to be underrepresented. Recent studies show that persons over age 60 comprise anywhere from 2.5 to 9 percent of the homeless, while they are 15.6% of the general population. (Institute of Medicine, p.16-17). This underrepresentation is puzzling because the elderly appear to have unique vulnerabilities to homelessness. Elderly on fixed incomes are caught in a growing shortage of low-income housing. Gentrification, demolitions, federal program cutbacks in the last decade, changing tax benefits, and pre-payments and buyouts of federal mortgages on rent-subsidized buildings have created a shortfall in low rent housing which is expected to get much worse in the next few years (National Housing Task Force, 1988). The housing related problems of the elderly are great and growing, but how are they related to homelessness? This study explores the connection between the growing shortage of low rent housing, the unique housing related problems of the elderly, and homelessness itself.

Study Purpose and Approach

In order to learn the characteristics and housing patterns of older persons in Chicago, a sample of seniors who have experienced serious housing problems *including* homelessness was identified from persons who have been served by the Chicago Department of Human Services Emergency Services (ES) program. This program responds 24 hours per day to approximately 125,000 calls per year, about 11% of which involve senior citizens. It is an ideal data source from which to identify persons who potentially have housing problems and are not necessarily receiving ongoing services. Half to four-fifths of the senior emergencies to which the agency responds are housing related. The most frequent problems are fires, need for temporary shelter, wandering, and need for transportation; most persons (78%) are seen only once, but 10% of clients are seen three or more times.

A random sample of 479 ES clients age 60 and over was drawn, revealing them to be older and more likely to be members of a minority than the city's aged population, and consequently poorer and in poorer health. Two "housing risk" samples were identified--those

who most often had multiple problems and repeat contacts and who at last contact with ES had a) needed temporary housing or shelter or b) were living in deplorable housing conditions. One-hundred twenty-six of these housing-problem clients were selected for interview.

This report compares these two housing emergency groups with similarly aged low-income residents of SROs throughout the city, residents who are also at risk for housing loss, given that SROs in Chicago are rapidly disappearing. But having not necessarily experienced emergencies that required official help, we expected SRO residents to be distinguished by identifiable strengths, resources, and coping capacities. The comparison allows us to more clearly see the residential histories and associated problems which make old persons vulnerable to housing loss.

From July through November 1988, researchers attempted to locate the selected ES clients, contacting all residences, agencies, friends and relatives noted in the agency records. In-person qualitative interviews and assessments using the Duke University Older Americans Resources and Services (OARS) Functional Assessment Instrument were conducted with 91 ES respondents who could be located and informants who knew them. The assessment covered health and mental status, cognitive impairment, functional capacity, social support, and housing history. Exploratory discussion about the chronology of housing problems identified critical combinations of factors that appear to precipitate emergency situations. ES clients who could not be located appeared to be the chronically undomiciled, or persons who had left the city or died.

Key Findings

1. Shelter use by the elderly is usually very short-term, but "homelessness" describes a wide variety of diverse and complex situations.

The traditionally identified homeless continue to be "young old" single men, frequently dependent upon alcohol, somewhat disabled, occasionally doing odd jobs, who formerly stayed periodically in the cheap hotels and flop houses in places like West Madison Street. They now fend for themselves utilizing shelters and soup kitchens. They still comprise the bulk of the long-term homeless, but they have become more visible throughout the city in recent years with gentrification. Women who regularly use shelters are joining this group in increasing numbers, partly because they tend to live longer and have even fewer economic resources than men. This group, who are homeless for a year or more, represent only from two to five percent of all ES clients in a given year.

However, the vast majority of older ES clients who experience homelessness have had short-term rather than long-term episodes. Typically these are persons who live alone and whose locational or personal attachments are limited for a variety of reasons. They are especially subject to evictions for forgetting or refusing to pay rent because they suffer from dementia, alcoholism, psychiatric problems, or declining health. This group represents at least 15 to 20 percent of all ES clients in a given year, and possibly more.

These briefly homeless individuals are likely to become insitutitonalized or to disappear into deplorable housing conditions because of lack of housing options. The common risk of those without housing and those in deplorable housing is their shared vulnerability created by poverty. Very low monthly income, but also poor health and isolation are most likely to lead to their not having the money to pay rent and to eviction. Deterioration is less risky for older persons in SROs, congregate housing, or other more communal neighborhoods where informal assistance is available, or personal relationships have been of long duration.

2. A significant proportion of the elderly are vulnerable to loss of their homes, partly because of inability to manage and care for them.

Homelessness, then, is not the ultimate measure of poor quality of life. Those in deplorable housing receive even less informal or formal help, and they rate even lower on the total functional assessment than the homeless group. They are also less likely to be involved with friends or agencies of any kind. Despite being somewhat more likely to have children or other relatives involved, their situations are extremely difficult to deal with. Guardianship is frequently recommended but difficult to establish for persons without relatives. Agencies' inability to respond to the deterioration of such persons can have disastrous consequences. When forced to relocate, the largest proportion of such clients go to nursing homes or places unknown. Of those who go to nursing homes, most do not live long.

A number of underlying factors help explain how such seniors end up in precarious situations and why, in many cases, services are not received until the situation reaches crisis proportions or, in some cases, never reach them at all. Emergency shelter, one of the most expedient resources available, is used to a substantial extent. Permanent resettlement is usually only made from a hospital to a nursing home, and only when the client already has no other options or does not have long to live. Some clients who remain in deplorable housing without assistance die through trauma and accidents, acute and preventable illnesses, or through inevitable deterioration due to chronic conditions. Deterioration is expedited by

neglect.

3. Factors that precipitate the loss of and incapacity to manage their homes include living alone and lacking social supports, diminished mental functioning, and very low incomes.

Most elderly experience some decline in health and functional capacity, number of social supports, and sometimes in economic and mental capacity, but the combination of these deficits is the most potent factor in losing one's home. Loss of mental capacity is the most salient factor, but loss of income, loss of financially supportive persons who share household expenses, and evictions are the clearest precipitants of homelessness. Without these predisposing factors and trigger events, some seniors remain in subminimal housing in a condition sometimes worse than that of the homeless.

Aloneness and lack of social support

A lack of social resources most clearly distinguishes the homeless. Loss of social support one depends upon, compounded with reclusive isolation, personal neglect, and/or depression or other mental problems are very serious, as is loss of any of the other resources for those whose reserve of social resources is already low. Isolation is a critical factor in the situation of those in deplorable housing conditions.

Diminished Mental Functioning

Among elderly ES clients, diminished mental functioning resulting from loss of cognitive capacity, psychiatric disorders, and chronic alcohol abuse is the most prevalent corollary with emergencies, affecting 20 to 30% of ES clients, especially the very old. This suggests that a substantial portion of the city's elderly are at risk and that, in the absence of other programs, city agencies (police, fire, and human services as well as aging programs) bear a large responsibility for their management. Behaviors that are a product of dementia-- wandering, getting lost, and being unable to manage personal space and business--are a common reason seniors get referred to ES and other agencies. Fully half of the interviewees who were ever homeless and one-fourth of those in deplorable housing conditions present evidence of psychiatric or cognitive impairment. This makes homelessness among the elderly inherently different from that of younger populations.

Dementia is often confused with and compounded by psychoses and depression. Although dementia is common among the ES clients, among the those homeless and in deplorable conditions there was a substantial amount of psychiatric impairment, and significantly more

psychosis among those who had been homeless. Unfortunately, very few receive any psychiatric treatment, although many are placed in nursing homes.

Very Low Income

A key distinction between the ever- and never-homeless is a relatively small amount of monthly income, between $595 and $434, and the income for the currently homeless is much lower than this. With SRO rents averaging $250, the margin for those who become homeless is simply too slim to secure or retain stable housing. A substantial proportion of those interviewed are not receiving all the income and in-kind benefits to which they are entitled due to lack of access, information and incapacity to apply.

4. The shrinking supply of low-income housing and scarcity of supported living environments like SROs make relocations increasingly difficult and contribute to a growing need for high cost institutional care.

Chicago's loss of SRO housing is having serious consequences for the very poor elderly who are likely to be homeless, who live alone and who have few other available social supports. They cannot compete effectively for an ever shrinking supply of affordable rental units and cannot maintain the physical space. Service agencies often find that when finally forced to move from affordable quarters, clients have already deteriorated substantially, so that nursing homes are the only alternative available. Persons who live on the street for a long time, when finally forced to accept placement, also can be "kept" only in institutions. Alternative housing, allowing autonomy, but also facilitating service is badly needed as a permanent alternative.

Conclusions and Recommendations

This study has identified an extremely high risk population of elders who are difficult and expensive to serve because of either lack of, tenuous, or pathological attachments to their residences. Having experienced an emergency to which city agencies have responded, those in deteriorated housing conditions present quite different needs from those who have already become long-term homeless. Both groups often rebuff the attention of agencies and, given their great needs, alternatives are extremely limited. While the latter group receive some agency attention because of their visibility, the former are less visible, but in no less serious physical and mental condition.

We have examined one housing resource, SROs, where some elders live relatively well because of the low cost, availability of informal supports, and incentives to maintain independence. This resource, is in short supply, but it provides a model for delivering services non-intrusively

These findings suggest a need for more innovative and intensive outreach and service delivery to elderly persons before their housing condition or the effects of various losses force them to lose their residence also. We propose addressing the medical needs of these clients (which are substantial) as one avenue toward forming helping relationships with them which can also provide assistance to compensate for their cognitive deficits. Outreach programs to address the deterioration of their residences is a similar potential avenue.

A second program avenue would identify and utilize the existing informal supports in the client's environment to deliver services directly. Such programs would recognize, reward and/or compensate informal caregivers.

Such approaches recognize that keeping elders in the community in decent and livable surroundings will necessitate the commitment of ongoing programs responsive to clients' own perceived needs. Emergency interventions can only serve to identify such high risk persons; intensive services must be quickly dispatched, work with all resources possible, and be designed to maintain the clients until they die.

More knowledge about these populations is needed to inform service delivery to them. We recommend further research on the nature of the attachments elders feel toward "their place" and what reasonable adaptations are possible, the effects of relocations especially to temporary emergency shelters, and the particular coping capacities of persons who have experienced relocations, both voluntary and involuntary. Complementary research would examine policies about these same issues from the perspective of the agencies involved.

All the diagnostic resources, client service, and research in the world are not going to alleviate the growing crisis in urban housing. Until our nation adopts a federal commitment to "housing for all," developments in American cities are going to continue to force people with limited resources and marginal housing into homelessness. The cost to all agencies of "servicing" such persons appears to be far greater than simply housing them decently in the first place (Lipsky and Smith). The many services we have described here, that have been demonstrated and proven effective, do not work in the absence of a decent and affordable home.

CHAPTER 1.
THE SIGNIFICANCE OF HOUSING PROBLEMS AMONG OLDER ADULTS IN CHICAGO

Homelessness is growing among the elderly just as it is among every other age cohort in America. The elderly appear to have unique vulnerabilities to homelessness, yet are not homeless as often as we might expect. Their housing problems go far beyond simply being homeless.

Recent studies have found that persons over age 60 comprise anywhere from 2.5 to 9% of the homeless, while they are 15.6% of the general population. This apparent under-representation of the aged among the homeless may be due to their eligibility at age 65 to a number of public benefits (Social Security, Medicare, senior housing, etc.) which generate enough income to facilitate leaving the streets or to prevent them from becoming homeless in the first place. Or possibly the homeless do not survive to old age because this condition is so debilitating. Or it may be that this proportion merely reflects the sampling methodology of the studies, since most subjects are self-selected and include shelter residents or persons already seeking services. It is very possible that the elderly are less likely to use such services. It is widely acknowledged that shelters are dangerous places, and that younger homeless persons tend to "squeeze out" older ones (Insitute of Medicine, 1988).

Recent studies in Chicago (Rossi, 1986; Kutza, 1987; and Sosin, Colson & Grossman, 1988) and Detroit (Douglass, 1988) present a somewhat inconsistent picture of who the elderly homeless are. Street surveys suggest that they are largely men (Rossi), while samples from agencies serving elderly homeless clients are largely women (Kutza). Street surveys find the homeless elderly to be relatively young, between 55 and 65 (Douglass, 1988), while Kutza's agency data found the homeless to be quite old. Rossi found the "elderly" (age 55 and over) to be 19% of the homeless on the street and Sosin found them to be 12% of persons in his study at meal and shelter programs, while the city's population age 55 and over is 21.2% (1980 US Census for city of Chicago). So even in this city with a relatively high proportion of elderly among the homeless, they are proportionately under-represented. Elderly blacks are somewhat over-represented in all of these studies.

We have a less clear sense of the the general housing problems of the elderly that might be related to homelessness. We know the elderly on fixed incomes are caught in a growing shortage of low-income housing. In the past decade, gentrification, demolitions, federal program cutbacks, changing tax benefits and pre-payments and buy-outs of federal mortgages on rent-subsidized buildings have created a housing shortfall for the poor elderly in urban areas. This is expected to get much worse in the next few years because so little new construction is "in the pipeline" (National Housing Task Force, 1988).

Indeed, poverty, desperate housing problems, and near-homelessness are prevalent among identifiable sub-groups of the elderly according to city agencies: the Chicago department on aging, human services, fire and police. The Chicago Department of Human Services (DHS), the city agency charged with providing shelter as needed to elderly persons and providing emergency services on a 24 hour basis, paid for shelter for 600 different older persons in 1987. Nearly a third of the 82,000 emergency calls to its Emergency Services program in the first eight months of 1988 were housing-related, and over half of those to which the department sent out an emergency response team were housing related. Such housing emergencies included evictions, need for shelter, "deplorable housing conditions," fires, utility shutoffs, and being chronically undomiciled. A substantial proportion of these emergencies appear to be associated with homelessness, and many appear to be preventable.

Indeed, housing related emergencies appear to be proportionately even more common among older persons (over age 60) than among younger persons served by DHS (see chapter 2). Keigher (1987) found that at least half of these emergencies experienced by the elderly were housing related. Older poor persons who live alone and have no family ties are widely recognized for being at especially high risks (Butler and Davis).

The extent to which such problems lead to homelessness and institutionalization, however, is unknown. Keigher's study suggested that among the elderly, near-homelessness (deplorable housing conditions, fires, and having to relocate) may be as threatening to health, safety, and life itself as is the experience of having no place to live. Persons served in an emergency appear to be at a critical juncture which often leads to relocation. How they cope and the options available to them are important in considering what can be prevented. We need to know more about who is truly at risk and what their options might be.

Alternatives in such emergncies depend upon the availability of appropriate housing, but this supply is often highly inadequate, so that paid shelter, motels, and nursing homes are often used. In contrast to this, single room occupancy (SRO) hotels are one of the most affordable and flexible types of housing for inner-city poor people, although the stock of SRO housing in Chicago is limited and rapidly shrinking. In the gerontological literature, SROs have been widely recognized as socially supportive, convenient, and reasonably priced alternative housing for seniors. While often inadequately recognized as a resource, SROs sustain important informal helping networks and have been widely utilized by governments in time of necessity because of their convenience. Today the reduced supply of SROs is playing an increasingly important role to cities facing housing shortages and to all levels of government looking for market mechanisms to solve their problems. Given the current importance of low-income housing, a better understanding of the value of SRO housing to the poor elderly and of the elderly

who are coping independently there--persons who are not asking for nor using services--would be particularly useful.

Purpose

This study describes the characteristics and housing patterns of older persons in Chicago who have experienced homelessness and other serious housing problems. It compares those with housing problems with a sample of seniors living in SROs who are, presumably, coping more successfully. It compares their needs and resources, both internal and external. From these two populations, those selected because they had problems and the comparison group in a similar socioeconomic position who have not been served by ES we can learn also about successful coping. This can provide insight into factors that act as barriers to homelessness among the elderly and to ways SROs might be improved and strengthened as a housing option for the elderly on very limited incomes.

Methodology

The first portion of the study examines clients of the Emergency Services Division of the Chicago Department of Human Services, and other individuals who are currently living in SROs--two groups of elders who are living independently in the community, one who have had crises and one who have not. The second part examines a sample of the SROs themselves, their populations, their amenities, and the supports they provide for their residents. Below is a brief discussion of our methods of sample selection, data collection process, and analysis. For a more detailed discussion of methodology refer to the Appendix.

The Client Study

The client study includes two groups of individuals--those identified from the records of the Emergency Services Division of the Chicago Department of Human Services (ES) and those identified in our survey of SROs. Based on analysis of a large random sample of ES clients we identified two groups of housing related problems which appear to be very related to being at risk for relocation. We compare a selected sample of ES clients who have experienced a housing related emergency, 1) clients who "have needed shelter," with two other samples of older persons expected to be similar demographically, 2) ES clients who have experienced other housing related problems, and 3) persons living in single room occupancy hotels. The SRO residents were selected from hotels throughout the city in order to more clearly see their residential histories and associated problems.

Random sampling of the Emergency Services clients indicates that persons over age 60 are approximately 11% of the names in the files of ES. A random sample of 475 individuals was drawn from all cases of persons aged 60 and over whose records of contact are in the ES card files. The client files included cases for which the most recent contact occurred up to four years ago, so that case histories could be reconstructed retrospectively. Although ES does not do "case management," another unit, the Division of Youth and Family Services (YFS) Senior Unit, does provide follow-up.

Data from 475 randomly selected records were collected and the presenting problems identified. Using these data, a purposive sub-sample was selected consisting of 129 clients who at last contact with ES had a) needed temporary housing or shelter, or b) were in deplorable housing conditions. Comparison of the demographic characteristics of the random sample and the sub-sample indicates that there are no statistically significant differences between the two groups. In the SRO sub-sample thirty individuals living in the surveyed SROs were randomly selected and were willing to be interviewed. The same interview instrument was used in assessing both samples.

In addition to the respondent interviews, the process of data collection for the sub-sample of ES clients involved also gathering data from the YFS records on any contacts with that division of the agency. Information collected from the ES and YFS records includes client demographics, presenting problems, services needed, services provided, date and number of agency contacts, names of other individuals or agencies involved with the clients, and the client's last known address.

From July through November 1988, researchers attempted to locate the selected clients, contacting all residences, agencies, friends, and relatives that could be identified from the agency records. In-person qualitative interviews were conducted with located respondents and informants for both groups in the sub-sample. An assessment was made using an augmented OARS instrument. It includes health and mental status, functional capacity, social support,and economic resources. Exploratory discussion about the chronology of housing problems and relocations secured a housing history and identified critical combinations of factors that appear to precipitate emergency situations.

The Study of SROs

This study builds upon the findings from a 1985 study by Hoch and associates, *SROs: An Endangered Species*. Our objectives were to update our understanding of the value of SROs, to identify critical features of social and economic life in SROs that could be strengthened to improve residents' access to needed services, and to identify residents' options and preferences should hotels in three specific locales where their existence is threatened actually be lost.

First a representative sample of hotels was selected. All of the 18 hotels in Hoch's 1985 study (which were a stratified representative sample) were included in our sample. Additional hotels were selected according to the following criteria: 1) average rent was below $220 according to the 1985 data; 2) the hotel appeared to have a significant number or proportion of older residents; and 3) a contact person willing to talk could be located on site. The total sample was to include 4) hotels of varying size; and 5) each area in the city with a preponderance of low-rent SROs which are threatened. All areas represented in the ES client sample were included as much as feasible. Using these criteria, a total of 15 additional hotels were selected.

Actual data collection involved the following. A survey and interviews with hotel staff and with the residents who form the SRO client sample were conducted at 27 hotels, including 12 of the original 18 hotels and the 15 additional selections. In addition to the interviews with residents, a short questionnaire was completed with about 40 other older residents.

Statistical Tests and Methodological Limitations

The statistical tests used were difference of proportions, difference of means, and chi square. For all tests, the level of significance was set at the .05 level.

Because of the very short-term contact by ES staff with clients in emergency situations, much of the data are missing for the clients who could not be located during the study. While there were no statistically significant differences between the ES client sample and the sub-sample selected for interview, it was not possible to locate 23% of the individuals selected. The sub-sample actually located, on whom interview data were available, was also compared to the random sample. The located interview sample of ES clients differs from the random sample in having more problems noted and in having had more referrals to Emergency Services. Though the whole of the interviewed sample shows no significant difference in any of the demographic characteristics, we cannot conclude that no difference exists, since much of the these data were missing for the not located part of the sample. Therefore, the experiences of the interviewed sample were highly informative, but cannot be viewed as necessarily representative of all ES elderly clients.

Organization of This Report

The following chapters blend both a quantitative and qualitative examination of the data gathered on the 156 older Chicagoans selected for interview in this study. Chapter 2 describes the Emergency Service clients, their problems, and the services they utilize, then takes an indepth look at the interviewed clients on dimensions of need and impairment. It compares those reported to be in need of temporary housing with those who were in deplorable housing

conditions and those living in SROs. It further compares those who were ever homeless with those who were never homeless, and critically assesses where clients have "ended up" since their emergency. It concludes by identifying three factors that appear to be especially salient to the vulnerability of the elderly. Policy makers may choose to skip the details of this statistical analysis by reading the summry of relevant findings which appears at the end of the chapter.

Having characterized the kind of housing problem trajectories of the ES clients, chapter 3 presents some case histories of typical respondents, noting their coping capacities and the patterns of their residential moves. It makes a preliminary assessment of the organization of their lives and their attachments to their residence(s). Chapters 4 and 5 report on the findings from our survey of single room occupancy hotels. Chapter 4 presents findings of our survey of 27 SROs and discusses the implications of the demise of this shrinking resource for elders in selected parts of the city. Chapter 5 discusses the unique strengths of this autonomous yet supportive environment for some older persons and the lessons they offer for effective service delivery. While the worst threat is that so many SROs have closed in recent years, some important facets of such settings for seniors could be enhanced with minimal initiatives. Finally, Chapter 6 concludes that low-income elderly persons who have suffered housing losses and housing related problems have very special needs for intensive help and more effective interventions. Outreach and assistance would be more acceptable to seniors if it were more adaptive and supported by a partnership of both agencies and casual helpers in neighborhoods. Appendix A presents the methodology and design of the data gathering and analysis, and Appendix B presents supplementary data tables.

CHAPTER 2. OLDER EMERGENCY SERVICE CLIENTS AND SRO RESIDENTS: CHARACTERISTICS, PROBLEMS AND NEEDS

In this chapter, we use data available from agency records, to describe the characteristics of the random sample of 475 aged ES clients who might be vulnerable to housing problems, and to identify and then compare the housing risk sub-groups: those needing shelter and those living in deplorable housing. Following this, we report the more detailed information on client needs and services gathered through interviews with the sub-sample of housing related cases we were able to locate. We then compare the three groups interviewed: the ES shelter clients; the ES poor housing clients; and the SRO clients. Our purpose here is to be statistically descriptive and to identify significant factors. Some readers may not require this level of detail, and can find our significant findings in the summary at the end of this chapter.

Characteristics of Emergency Service Clients

Four-fifths of the older ES clientsare living in their own apartments or homes,11% are said to be living "on the streets" or in shelters, and 9% are scattered among SROs, nursing homes, and the homes of reltives (12% are unknown). Of those whose household composition is known, at least a third live alone, but household composition is unknown in 86% of the case records, and marital status is unknown in 91% of the cases.

Demographically ES clients are similar to the city's population age 60 and over, except that they are older and proportionately more black. Fifty-nine percent are female, as are 59% of the city's age 60 and over population. Forty-four percent are 75 or older, compared to only 26.5% for the city. Of those whose race is known, 45% are white as compared to 72% for the city as a whole (1980 census data). Thus older ES clients are more likely to be poor, because of their minority status, and disabled, because of their age. (See Table A1 in the Appendix.)

Though the data on the location of the emergency are missing on 28% of the cases, the available data indicate that emergencies tend to occur unevenly across the city, as shown on Table 2.0, second column (data are recorded by police district). The Wentworth district (2) has the most senior emergency cases, followed by Englewood (7), Grand Crossing (3), and West Loop (12). Districts with the highest number of housing related cases are nearly the same, districts 2, 7, 23 (Uptown), 12 (Monroe), and 24 (Rogers Park). The incidence of housing related cases appear to be related to poor conditions of housing in these areas, scarcity of low rent units, and visibility of those without homes, in addition to long standing patterns of poverty and racial segregation, especially on the south and west sides. The need for shelter particularly

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CITY-WIDE DISTRICT & AREA MAP

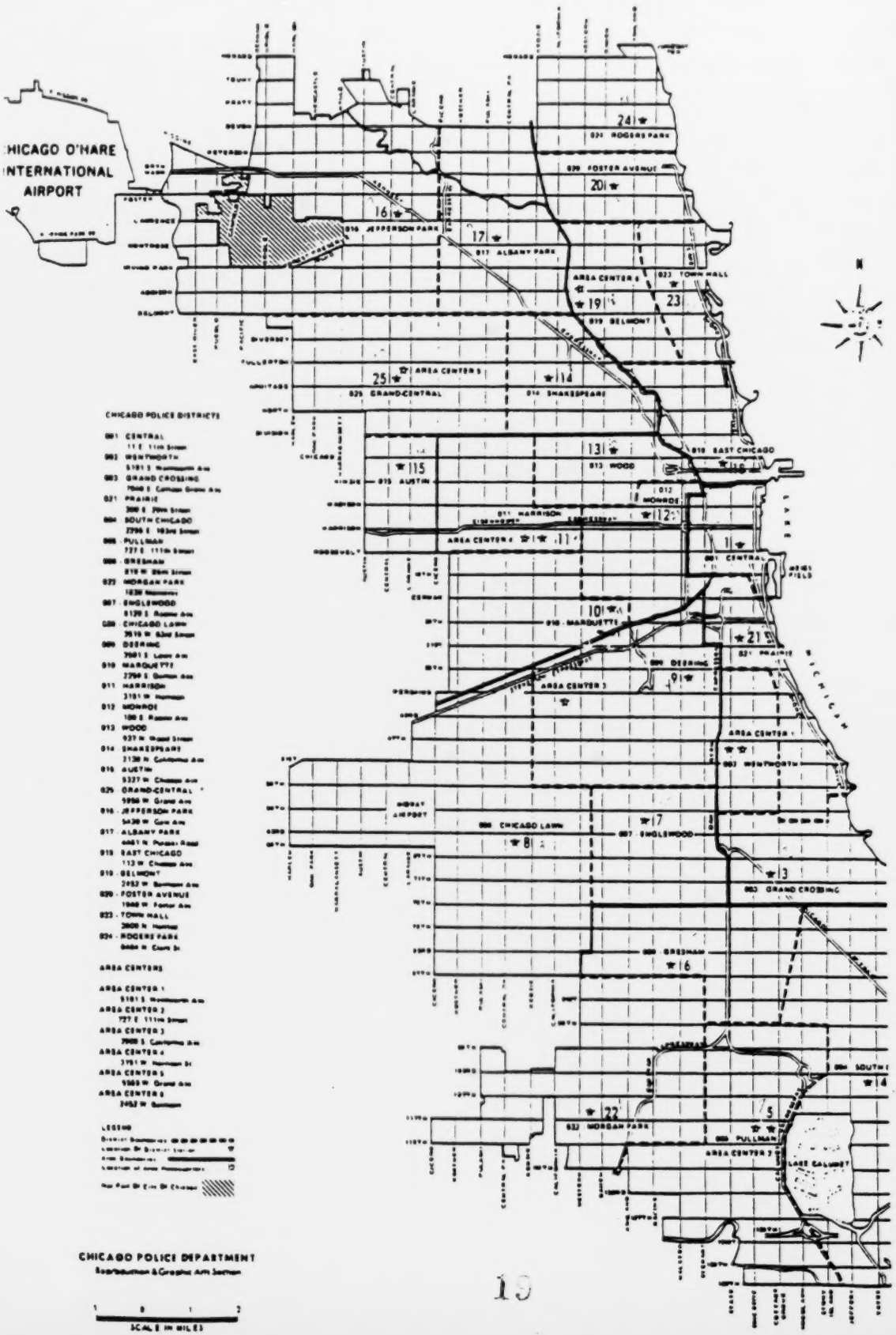


Table 2.0

ES Senior cases sampled by District and Type Interviewed

CPD District	Total ES Sr. Cases	Interview Eligible* by Type *Non Housing Related*	*Housing Related*	Type Interviewed *Hsg Cond.*	*Needs Shelter*
2	40	18	16	4	5
7	35	17	7	3	4
3	33	13	11	5	3
12	27	11	11		7
21	22	8	8	2	4
1	21	7	6	2	6
23	21	13	5	1	2
24	21	7	10		4
13	20	8	7	2	2
25	20	8	8	2	2
8	19	8	3		3
20	19	8	4	2	3
14	18	8	8	3	1
19	18	9	9	3	
11	16	8	3	1	1
18	16	7	6	1	3
6	15	9	3		1
4	14	6	2		1
9	14	2	8	2	3
15	14	10	3	1	
10	11	4	4	2	2
22	9	6	1		
5	7	4	3		1
16	7	5	2		
17	7	4	2		1
	464	208	150	36	59

CPD = Districts of the Chicago Police Department

* "Interview Eligible" samples only clients served from July 1, 1987-June 30, 1988. (Actual interviews included cases which were older than this.)

is clustered in neighborhoods that have been "urban renewed," but used to have a high concentration of SROs and flop houses.

Analysis of the problems presented at most recent ES contact reveals that about half of the clients present only one problem; but 29.1% present at least two and 7.6% present four or more. Certain housing related incidents, especially fires, rarely result in a second contact with ES, while multiple contacts often occur with certain types of problems, espeically with problems such as need for emergency shelter, and clients presenting evidence of multiple problems.

A wide array of needs are revealed by the problems to which ES responds. The most frequently listed primary problems are fire, being lost or confused, needing transportation,and needing temporary housing. (See Table A2 in the Appendix.) Analysis of only these primary problems shows that housing related incidents account for 47% of all contacts with ES, and a substantial proportion of the incidents involving "lost seniors" and the need for transportation (another 32% of contacts) also appear to be related to housing needs. This is especially true of clients who live alone or are homeless.

Undoubtedly, due to the focus on the immediate resolution of the emergency, many problems are overlooked or minimized in the data drawn from the ES records. Yet, it is noteworthy that mental illness or alcoholism are recorded in only 11% of the cases in the ES sample.

Client contact records indicate that the service provided is truly the emergency resolution that it is designed to be, as the vast majority of clients are never seen again. For example, 78% of clients are seen only once, 10% are seen 3 or more times, and 3.8% are seen six or more times. About 86% of cases are resolved in less than one week, while nearly 9% are seen over a period longer than a month. It is this latter group, the repeaters, that have multiple and more complex problems.

Of the 475 cases in the random sample, shelter is mentioned in the record for 158 cases, poor housing conditions for 59, fire for 97, eviction for 27, and need for temporary shelter for 96. As Table 2.1, below, indicates, there is considerable overlap among the problems with those who need shelter, more than those of any of the other groups. Note how few also experienced a fire. (Fires were usually the only problem noted.) The fact of repeated referrals implies that a substantial proportion of older persons needing shelter have other serious needs requiring further help from ES. These are more clearly identified by examining how problems cluster and how they persist over time.

Table 2.1 Problems occurring with need for shelter

Temporary housing and/or shelter	105
Temporary housing and/or shelter + fire	15
Temporary housing and/or shelter + eviction	15
Temporary housing and/or shelter + housing conditions	2
Temporary housing and/or shelter + fire + housing conditions	2
Needs shelter + fire + eviction	3
Needs shelter + fire + housing conditions	3
Needs shelter + housing conditions + eviction	2
Total	158

Of the 475 persons in the sample, 105 are seen more than once. These clients present a clustering of problems at each contact. Certain problem combinations tend to have corollary needs and to produce certain outcomes. For example, transportation is a corollary need for 32% of the clients needing shelter; temporary shelter is a corollary need for 19% of the wanderers and a resultant need for 33% of the evicted. (See Table A3 in the Appendix.)

Some problems are particularly persistent, being listed at both the first and the last contact. The persistence rate for "needs temporary shelter" is 68% and that for poor housing conditions 33%. Of the 54 cases in which either temporary shelter, shelter, or homelessness are mentioned, and which have multiple contacts with ES, the records indicate that in eight cases homelessness persisted for over a year. Most follow-up contacts occur rather quickly, especially with the group in need of shelter, but the high effort required with such clients by the ES teams suggests the need to look more closely at them and how they differ from the other aged ES clients.

The Housing Problems of the ES Clients.

The analysis described above identified four sub-groups for comparison: clients whose record with ES never mentions either poor housing conditions or need for shelter or temporary housing (A); those where shelter or temporary housing are mentioned (B1); those where poor housing conditions are mentioned (B2); and those where both of these problems are mentioned (B3). (See Table A4 in the Appendix.)

Race is unknown in 36% of the cases, making findings on this characteristic somewhat inconclusive. The housing risk group (B1-B3) appears to be significantly more likely to be white than the rest of the ES clients, but still less white than their population proportion in Chicago would *suggest.* The poor housing conditions group is the oldest, the most likely to be living in their own homes or apartments, the least likely to have been referred more than once, and the most likely to have been referred two or more years ago. There appear to be a declining number of housing conditions cases each year and they were the most likely to also have utility

shut-off problems. The group in need of temporary shelter has the highest proportion of men, the largest proportion that were living on the streets or in shelter, and the largest number that were referred within the past year. This group appears to be getting larger each year. The cases with both poor housing conditions and need for shelter have the highest proportion of women. They were the most likely to have multiple contacts with ES and multiple problems noted in the record. As we expected, the housing risks groups had significantly higher rates of both total problems and number of referrals to ES. (See Table A4.)

The Housing and Relocation Problems of Interviewed ES Clients and SRO Residents

While the interviewed sample differs somewhat from the larger random sample, it basically provides significant information about the ES clients. Substantial difficulties were encountered in attempting to locate them (see Appendix A), especially those who move a lot or have been without a home for long periods. The interview sample consists of the 91 ES clients aged 60 and over on whom complete data was gathered (37 with a history of poor housing conditions and 54 with need for temporary housing or shelter) and 27 SRO residents aged 60 and over. The categorization of clients is based on the nature of their most recent ES contact only (so combination cases are eliminated). Detailed analysis of the social, economic, and health situation of these sub-groups (presented in Table 2.2) follows, based on our coding of both client history data and data from the client assessments.

The interviewed sub-sample contains more blacks, more people living in their own homes or apartments at last ES contact (these were easiest to find), and more with multiple referrals to ES and with more recorded problems (more information made clients easier to find). (See Table A5 in the Appendix.) The number of problems and number of ES referrals are the same. The located clients are also somewhat younger and are less likely to have been undomiciled at the last ES contact. (See Table A6.) Thus, the located clients had some characteristics that made them more readily located.

Comparing the Shelter, Housing Conditions and the SRO interviewees we find the SRO sub-group has more males, is younger, and is less likely to be married or widowed. They are also receiving substantially more informal help, are more mentally intact, and have relatively low levels of need (as indicated by relatively low scores on our assessment instrument). Thus the SRO clients are substantially better off than are the ES clients, as was expected (See Table 2.2.).

Table 2.2 Comparison of sub-groups of interview sample

Variables values	Inter. elig. n=156	Shelt. need n=78	Hsg. Cond. n=48	SRO n=30
Sex, % female	48.7	46.8	66.0	26.7
Race, % white	42.9	48.5	35.1	40.0
Age, mean	74.6	77.1	74.6	68.5
Marital status				
% unknown	38.5	44.9	52.1	0
% never married	36.5	16.7	14.6	50.0
% separated or divorced	24.0	11.5	10.4	30.0
% widowed	21.9	16.7	10.4	10.0
% married	17.7	10.3	12.5	10.0
Number of ES referrals				
1	46.7	51.4	69.6	
2	11.3	13.5	15.2	
3	3.3	4.1	4.3	
4	5.3	8.1	4.3	NA
5	3.3	2.7	6.5	
6 or more	12.7	20.3	0	
mean	2.5	4.7	1.3	
Number of Problems identified				
1	17.9	23.0	19.1	
2	28.5	29.7	44.7	
3	17.9	24.3	19.1	
4	8.6	13.5	6.4	
5	4.6	4.1	8.5	
6	2.0	2.7	2.0	
7 or more	1.3	2.7	0	
Last known living arrangement				
SRO/rooming house	23.7	5.1	0	100.0
Apartment	17.3	19.2	25.1	
Nursing home	12.2	14.1	16.7	
Owner occupied home/condo	10.3	6.4	22.9	
Streets or none known	7.1	14.1	0	
Hospital	2.6	3.8	2.1	
Other	1.9	2.6	2.1	
Senior congregate housing	1.3	2.6	0	
Room and board	1.3	1.3	2.0	
Shelter	.6	1.3	0	
Halfway house or detox unit	.6	1.3	0	
Rented house	.6	0	2.1	
Deceased?	21.2	28.2	27.1	0
% receiving informal help	39.7	35.1	32.6	76.6
% receiving formal help	27.6	28.9	23.9	33.3
% intact dementia score	34.0	19.2	21.7	96.6
Mean OARS Score	15.7	17.0	17.3	11.3

Placement in Shelters

Need for shelter did not necessarily mean that a client was placed in shelter, and sometimes clients with other needs also were placed in shelter. Investigation revealed that 83% of those clients identified as needing shelter actually use it; 25% of those with poor housing conditions also use shelter. Clients who use shelter have significantly more noted problems and referrals to ES. (See Table A7.)

"Shelter" was defined as any agency provided housing which by its own definition is temporary, e.g. either overnight or transitional shelters which have limits on the duration of stay. We found we had to extend this definition to also include hotels and other facilities used by city agencies for shelter (e.g. rooming houses, congregate living facilities and nursing homes) as well as transitional shelters that have the potential of becoming permanent situations. Most of the "senior shelters" utilized by ES do allow and even facilitate the shelter clients in becoming permanent residents. The questions then arise, at what point does or should DHS stop paying for shelter there and when is shelter no longer temporary, but has effectively become a home.

Reasons for not using shelter for those "needing shelter" fall into two general categories--client initiated and system or agency initiated. Examples of client initiated reasons are a client refusing shelter or a client disappearing before receiving services. Examples of system initiated reasons include shelters being full, a shelter refusing to admit a client for some other reason and client's home being located. As Table 2.3 indicates, for housing condition clients, reasons for non-use are more likely to be system initiated, while for clients in need of shelter, reasons are more likely to be client initiated.

Forty-five percent of the individuals who used shelter are never truly homeless except by definition of being in a shelter. In other words, there appears to be other housing in which they are living they are sheltered, but it is uninhabitable, unenterable, too dangerous, or could not be located. This finding requires a closer look at the connection between homelessness and the use of shelter use for these persons. We find some non-congruence between use of shelter and "homelessness" which is discussed later.

Homelessness

The study examines three dimensions of homelessness: whether the individual was ever homeless and is still homeless; whether homelessness is short-term or long-term; and whether it is a single episode or is repeated. We were interested in the extent to which all three

of the housing risk groups have experienced homelessness, whether they are currently or had ever been homeless and the duration of that homelessness.

Homelessness was distinguished by its duration, with "current" being at the time of the researchers' contact and interview, "ever" meaning ever in the respondent's adult life, and "never" being just that. Using the definition operationalized by Sosin and associates (p. 22), with some additional parameters (in brackets), we defined "homelessness" as: 1) residing for up to two weeks with a friend or relative, not paying rent, and not being sure that the stay would surpass fourteen days; 2) residing in a shelter [or other agency-paid temporary housing]; 3) being without normal, acceptable shelter arrangements and thus sleeping out-of-doors; or 4) residing in a treatment center for the indigent for less than ninety days [eg. a hospital, detox, mental health, halfway house, or shelter for battered women] and claiming to have no place to go. In keeping with Kutza's criterion, "long-term homelessness" is defined as being homeless continuously or repeatedly for a period of one year or longer.

Of the 137 ES clients and 27 SRO clients for whom data are available, 35% of the ES clients and 78% of the SRO clients have never been homeless. Of those interviewed, 51% were homeless at one time. Of these, a third were homeless more than once and 28% experience long-term homelessness. Of all those who experience homelessness, over half were homeless only once and only briefly. (See Tables A8 and A9.)

Being homeless, however, does not mean that the older person had stayed in a shelter. Of the 57 interviewed individuals who were homeless at some time, 49% had actually stayed at a shelter. Of those who did not use shelter, nearly two-thirds avoided placement themselves, while for one-fifth, the service system did not provide the shelter they may have needed. For one-seventh, both client and system initiated reasons operated to prevent the use of shelter. (See Table 2.3.)

Demographic comparisons of the ever- and never-homeless groups reveal no statistically significant differences. In terms of frequency of homelessness, however, having been homeless once, blacks are significantly more likely to have additional periods of homelessness ($t=2.01$, $df=46$, $p=.050$). (These data are displayed in Tables A10 and A11.)

Two other problems correlate significantly with homelessness. These are a history of eviction, and evidence of impaired mental functioning. The latter problem includes dementia, but also mental illness and depression which are readily misperceived as dementia. Alcohol or drug abuse, while present among over three-quarters of those who were ever homeless, is not significantly more common among them. Being burned out, handicapped, or abused also show no significant differences in frequency between the ever- and never-homeless. (See Table A12 in the Appendix)

Resources Make a Difference

A number of specific social factors normally considered to be of support to older persons (number of and contact with children, living with others, availability of formal or informal helpers) show no significant differences between the homeless and the never homeless groups when considered one at a time, as displayed on Table A13. However, significant differences are found in some of the areas of the OARS evaluation that was used to assess resources and functional level for the interviewed sample.

Individuals who were never homeless score significantly better in total social resources, mental health status, activities of daily living, and in the composite total OARS score. The never homeless also have significantly larger incomes, and significantly less dementia (see Table 2.4) as scored on the Portable Mental Status Questionnaire. We found no difference in physical health, or in other economic resources except for monthly income. We would conclude, then, that certain critical *combinations* of deficits in resources certainly do make a difference. These two critical factors are deficits in cognitive capacity and monthly income.

When the SRO group is compared with the ES group, they show better overall functioning on average. Regardless of whether or not they were ever homeless, the SRO group is less likely to have had children, or to be in touch with their children; most are helped by neighbors or hotel staff rather than by relatives; and they have higher monthly incomes than ES clients. Their "better off" status is not due to their being younger than the ES clients either. They are obviously supported by non-traditional factors.

Chapter 5 explores some possible explanations for their better status.

In conclusion then, the interview data suggests that the higher incidence of dementia and of lower monthly incomes sharply distinguish the ever homeless and the never homeless, but the compounding effects of the lack of resources of all types is also important. The SRO group, while having equally poor health and economic resources, appears to be better off generally because of the social support and contact available in their immediate surroundings.

Finally, the stability of client residential history and outcome was examined by assessing the stability of interviewees' current living arrangement and tracking the stability of past living arrangements. The living arrangements of the never-homeless are significantly more stable presently than those of the ever-homeless ($p = .04$). The ever-homeless also exhibit a significantly higher level of housing instability in the past ($p = .000$) having a pattern of evictions, relocations and returns to shelters and the streets. (See Tables A15 and A16 in the Appendix.)

Table 2.3 Reason why shelter not used

Reason for Non-use	All ES Sample n=91	Hsg Cond n=37	Shelt n=54
Not applicable	27	5	22
Client initiated	27	8	19
System initiated	29	21	8
Both	6	1	5
Unknown	2	2	0

Table 2.4. Resources by whether or not ever homeless

Variable	Group	n	Value	df	t	p
mean income	Never	37	595	56	2.23	.030*
	Ever	38	434			
Social resources score	Never	37	2.62	74	-3.14	.002*
	Ever	39	3.54			
Economic Resource score	Never	36	3.03	72	-1.2.	.235
	Ever	38	3.33			
Mental health score	Never	37	2.68	75	-2.70	.009*
	Ever	40	3.30			
Physical Health score	Never	37	3.49	73	-0.51	.610
	Ever	38	3.59			
ADL score	Never	37	2.76	74	-2.02	.047*
	Ever	39	3.32			
Total OARS score	Never	35	14.3	69	-3.73	.000*
	Ever	36	17.1			
Mean dementia score	Never	36	1.31	56	-2.94	.005*
	Ever	36	1.92			

In terms of where the 91 located ES clients "ended up," of the 19 who were undomiciled at the last ES contact, 7 were still undomiciled when our researchers contacted them. Of those who relocated, the last known living arrangement for was found to be:

hospital	3
nursing home	3
R & B	1
congregate housing	1
own apartment	2

Eight of the ever-homeless are dead as are 9 of the never homeless. Thus, of that small group of clients who had had repeated contact with ES and we could locate, at least one in three are still on the streets after one to four years. Very few were ever resettled in normal housing. Less than a third were in room and board or independent housing. This is clearly a population which is very difficult to move into normal housing.

Summary

Statistical analysis of the demographic characteristics of the random sample indicate that black elderly, the poor, and individuals over 75 years of age are over-represented among the ES elderly clients. Emergencies for the elderly appear to be spread fairly unevenly across the city. Neighborhoods having an abundance of run down housing show the most seniors in deplorable conditions, and neighborhoods with a shortage of low rent housing show the most in need of temporary shelter. About half of elderly ES clients present only one problem, and nearly four-fifths are seen by ES only once. Most commonly occurring problems are fires, being lost of confused, needing transportation, and needing temporary shelter. Housing related incidents account for at least 47% of all elderly contacts with ES, and probably much more. Only 7% of the clients are referred to ES four or more times, suggesting that the vast majority cope in emergencies largely on their own.

Multi-referral clients have multiple problems and at least a third of them have a need for shelter. Housing related problems are very persistent, with shelter need persisting from the first to the last contact in 68% of the cases and poor housing conditions persisting for 33% of those cases.

Data on services reveal that shelter is provided by ES to seniors for a wide variety of problems. Most shelter use is of limited duration but a small group of the elderly go in and out of shelters for a period longer than one year. When clients need shelter but are not placed, reasons have as much to do with agency inability or unwillingness to place them as with client unwillingness to leave a home in deplorable surroundings.

Client assessments of those who were interviewed reveal that ES clients with housing related problems are substantially worse off than SRO residents despite having similar levels of economic resources and health problems. A major difference between them is the higher level of cognitive impairment for the ES clients.

ES clients have had more than twice the incidence of episodes of actual homelessness as do SRO clients. Of both groups, thirty-three percent of the clients who have ever been homeless are homeless more than once, and 28% experience long-term homelessness. Two problems that correlate with homelessness are a history of evictions and current cognitive impairment, usuall dementia.

Finally, analysis of the ES clients' recent living arrangements indicate that at least 20% of them have died and a similar number have been institutionalized in the one to four years since the most recent ES contact. We do not know yet whether this is an excessive proportion, and it may not be given their ages, but the gravity of their circumstances is revealed in the extent to which they have suffered trauma and preventable medical conditions. This is a population that is very difficult to ever move back into normal, decent housing. In the next chapter we discuss some of the tragic events that led to many of their deaths. With these descriptive parameters in mind we will next examine the unique patterns in the experience of older individuals who have been assisted by Emergency Services. We are extremely grateful to the individuals who have provided this information, but in order to protect their privacy, with the exception of identified agencies and one of the hotels, all individuals' names have been altered in the following chapters.

CHAPTER 3. THE EMERGENCY SERVICE CLIENTS: COPING WITH THREATS TO AND LOSS OF "HOME"

Leo Tolstoy began his novel *Anna Karenina* with the observation, "Happy families are all alike; every unhappy family is unhappy in its own way." And so it is with elderly persons faced with imminent loss of their homes or their independence: the variations in their individual circumstances and coping capacities are unlimited.

Interpretation of statistical analyses alone cannot begin to convey the overwhelming significance, pathos, and complexity of the circumstances, nor the strengths and fierce survival instincts of the seniors described in the previous chapter. To do so more meaningfully, this chapter presents four overall profiles of the elderly ES clients we encountered, including general descriptions of the commonalities and variations in their housing problem situations from a more holistic, in-context perspective. This does not yet represent as thoroughly systematic a qualitative analysis of all cases as we plan to do at a future date.

These cases highlight several issues and emerging themes in the lives of older individuals who have experienced serious, sometimes life threatening housing related emergencies. Examination of how individuals cope in the face of housing difficulties offers valuable information on how it is that some become homeless and some do not. The following qualitative description suggests the meaning that housed and homeless situations have for elderly people.

These cases and general descriptions are organized around those who have ever been homeless and the never homeless. Within each category brief attention is given to different kinds of homelessness, different kinds of housing situations and different patterns of relocations. Preliminary analysis of their coping abilities suggests wide variation in the receptivity of the elderly to service interventions and in their reasons for use of shelters.

Coping Abilities of the Homeless

The One Time, Short Term Homeless

The majority of our cases of homelessness were individuals who were homeless only once for relatively short periods of time. Many of the one time homeless drew on formal and informal social resources to pull them out of their homeless state and, as we have indicated earlier in this report, most are no longer homeless. The sometimes multiple events surrounding slippage into homelessness include evictions, fires, loss of social supports, loss of income (eg., due to a mugging, loss of a spouse's income), inability to manage funds due to diminished mental capacities

or alcoholism, fears or paranoia resulting in a self-intitiated move, and so on. In addition, their ability to cope in both preventing and finding a route out of homelessness varies considerably.

The following case description illustrates the inability of an elderly woman to cope in the face of diminishing social (and likely economic) resources and encroaching dementia. These resulted in the loss of her home, her subsequent adaptation to shelter life and efforts to maintain a sense of "home".

Josie Hicks: Homeless in Her Own Home

Josie Hicks, 85 years old, presents a case of ill-defined homelessness in some ways complicated by those attempting to help her. From Josie's perspective, she was never homeless and still has her home. She is homeless by our definitions because of the change in status of no longer owning her home and because she was placed against her will in a shelter where she still resides. We found Josie, a likable and talkative black woman, still living at the transitional shelter she had been placed in over a year before. She has no idea how long she has been there. This particular shelter takes in only elderly people and effectively operates as a sort of nursing home/boarding house. Josie has settled in, behaves as if this is her home and appears to have no plans to leave. However, her recall of the events that brought her there is scant and inaccurate in time frame.

Josie was born and raised in Tennessee and came to Chicago in her 20's to visit her uncle. After returning to Tennessee to get married, the first of three childless marriages, she came back to Chicago and married again. In her late 40's she purchased a large house with her mother and sister and lived there close to 30 years, first with family and more recently with friends. All of her family, except for two adopted daughters (who may be cousins) are deceased. She worked on and off throughout her life and was proud that she had recently attended a party for retired workers at the Drake hotel.

Josie lived illegally with her elderly boyfriend and others in her family home after the city confiscated it for delinquent taxes. Several reputed gang members lived here too.

ES encountered Josie in the hospital after a burn accident in her home. She had been living in her house with a boyfriend of 8 years, Bob, who had reportedly served time for murder, another elderly white man (Joe) and later several younger residents,

whom Josie does not recall, including alleged gang members. A neighbor lady occassionally visited and/or cooked for Josie and the elderly men. According to those who knew her, Josie's mental and physical condition declined considerably in recent years and she had started drinking heavily sionce meeting her boyfriend. Although she was not asked about her drinking she repeatedly denied such behavior during the interview. She had apparently lost her home due to deliquent taxes and was living there with no utilities in "deplorable conditions."

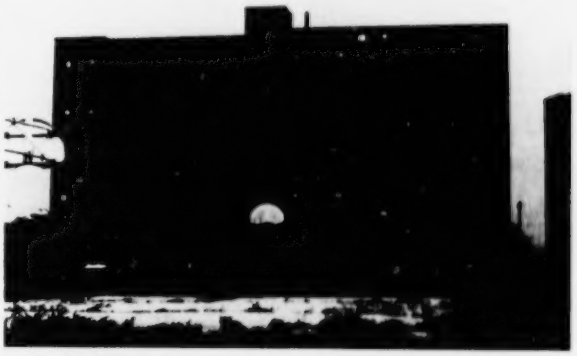
Over the next year ES, with followup from other agencies, twice removed her from her home (once after she wandered back there), placed her in the above mentioned shelter and secured a state guardian. According to ES and a neighbor, by the time she was removed from her home the second time Bob had died. Joe froze to death in the house shortly after her removal. Josie was obviously reticent about having to leave her home and frequently expressed concern for her possessions. She told us she left her home out of her own choice because she didn't want to live there by herself after "everyone had died" (implying that both Bob and Joe had died before she left). She feels that if someone "reliable" could have lived there with her, she would have stayed, but "when an old woman lives all alone people take advantage of you."

Currently Josie remains a long term resident at the shelter and she was unsure about the amount and whereabouts of her income. Shelter is no longer being paid by the City and the state guardian has been attempting to place her in a nursing home. Josie, however, likes the shelter and is attached to her "girls" there. She maintains for herself the image of having a home and a friend in her old neighborhood and talks about how she could visit. At the same time, Josie has been uncooperative in making nursing home plans, stating she is comfortable where she is. Despite her dependency and inability to maintain her life in the community, she struggles to maintain some sense of autonomy by refusing nursing home care, although she is essentially institutionalized in a shelter. She has coped with the crisis of being taken out of her home by redirecting her attachments to shelter staff and believing that she still has her house and neighborhood, even though she knows she cannot return to it.

In Josie's case, some kind of institutionalization appears to be imminent. As we have noted before, this is not an uncommon outcome, especially for those who entered a homeless state in part due to dementia or other mental difficulties. An inability to cope, to effectively maintain (and remember) social networks and to manage daily (eg. financial) affairs are characteristics of a number of elderly people who enter the ranks of the homeless. However, not all those who become homeless are so vulnerable or so amenable to intervention by service providers. Those who are largely mentally intact and/or more resistant to service more often turn to their own or informal

social resources to regain housing.

For example, Lawrence Smith, a 72 year old divorced black man who is extremely frail, near blind but mentally intact, was evicted and homeless for a relatively brief period. Although ES secured shelter for him he refused to leave his south side neighborhood, stating he could stay with a friend, which he apparently did for a time. When interviewed, Lawrence denies that he has ever been evicted, saying that at the time he had already applied to CHA senior housing with the help of a friend and had left his prior apartment of his own accord. Despite his physical and financial vulnerability, Lawrence, and others like him, maintains a relatively independent and stable lifestyle with informal support. His pride and attachments to his friends and neighborhood prevent service providers from having any impact.



CHA Senior buildings are the alternative most often chosen by the elderly who must relocate because they offer affordable rent. Waiting lists are long.

Eleanor Jackson, an elderly black woman who never married is much like Lawrence in that she was able to rely on friends for assistance after she became homeless due to a fire. However, it took Eleanor much longer to find housing in part due to a weaker social support system and less organized mental capabilities (possibly mild dementia). She apparently alienated herself from many of those who helped her and was always hard to "keep up with." Eventually, after staying with a series of friends, she received formal help from a private agency in locating and moving to new housing.

Although many of the one time homeless come from fairly stable, long term housing backgrounds, this is not always the case. For instance, Margaret Scarola, a long divorced 70 year old woman, is strong headed, independent and healthy. She became temporarily homeless after leaving a boarding house where she felt she was being "poisoned." Despite her mental vulnerabilities and paranoia, Margaret was able to find housing in an SRO on her own after staying in a shelter until she got her next Social Security check. She has moved frequently, both in housing and jobs, and left several prior housing situations due to her recurrent fear of being poisoned. Despite her transient lifestyle, her organized and somewhat overzealous approach to daily activities allowed her, for the most part, to secure new housing relatively quickly and easily. However, when confronted with questions about homelessness, Margaret seems terrified by the thought of having no place to go. She adamantly claims that "I'm not homeless myself--that's all I

know!" If Margaret's mental state were to worsen and other factors were to change she could be at risk for repeated homelessness.

The Long Term and Repeatedly Homeless

The actual number of long term, chronically homeless "street people" repesented in this study is relatively small, but their enormous needs and unique coping strategies deserve separate attention. Although we, and even the chronically undomiciled seniors themselves, may not know what precipated the loss of a home, having become long term homeless they are the most difficult to pull out of their homeless state. In one sense, they have adapted to life on the streets such that a neighborhood, a park or bench becomes their "home." Developing attachments to a lifestyle (albeit a difficult one), fear of institutionalization, and fear of being taken away from familiar surroundings are among some of the difficulties service providers must deal with when attempting to improve the situation of the chronically homeless. The following case description aptly illustrates how one woman's coping strategies are both admirable and frustrating to service providers.

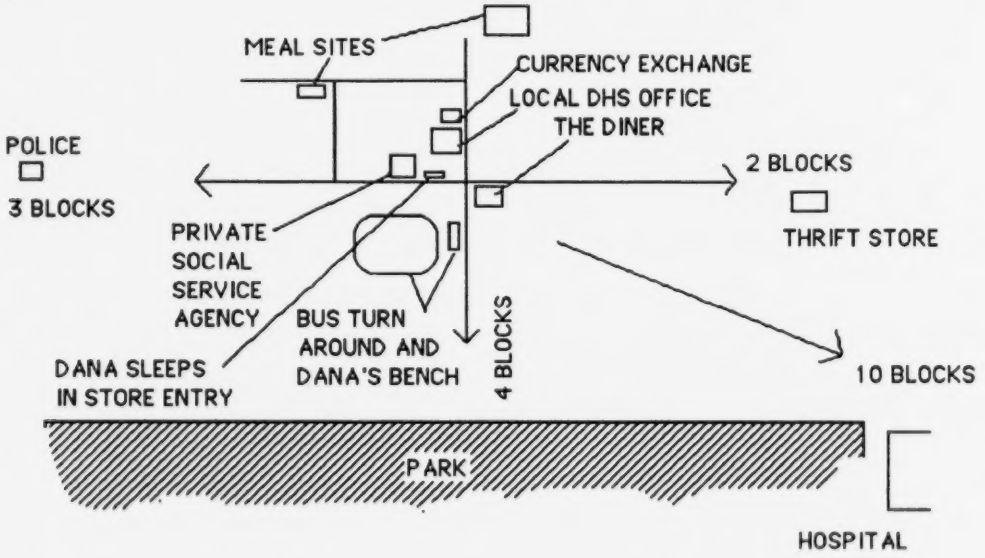
Dana Kaczmarek: Avoiding "Intervention" While At "Home" on the Streets

Dana, 62 years old and of eastern European descent, has lived on the streets in the same neighborhood for at least 11 years. Numerous agencies and people in the neighborhood have approached her and tried to assist her in getting shelter, services and housing, yet Dana still lives on her bus bench and sleeps in doorways and nearby parks.

No one is certain how Dana came to be living on the streets. Apparently she never married but had two sons while in her early 30's. She lived with her parents until they died, when she was probably left with no income for several years. At least one son visits her occasionally at her bus bench and sometimes lives in the neighborhood. Dana believes that he will take her in, as he has made comments to that effect in the past. However, he is now divorced and agency contact with him and the other son has been minimal.

Although it is unclear just how she initially ended up on the streets, Dana has clearly adapted to street life. She sleeps mostly in the day in regular places, showers in the park and dislikes shelters, using them only when it is very cold, preferring certain drop in and shelter services for women. She has been regularly refused from a number shelters due to her smell and incontinence. "Friends" on the street, where she is widely recognized, give her money which she "saves." She sometimes cooks in the park. She wears several layers of clothing, even in hot

weather, and buys "new" used clothing every few months as she has no way of washing it. Dana has received occassional food boxes from the local DHS office, meals at the local senior center, and is somewhat friendly with a few workers. Dana asserts, "I got everything I need in this neighborhood; it's convenient; stores are here; I go to the Diner or McDonalds. It's real nice outdoors. I like it here. I got sunshine." A rough tally of the resources Dana uses in the neighborhood reveals that her choice of this particular bus bench for a "home" is no accident. It is a rich environment, indeed. Some of the resources in her immediate neighborhood are mapped out below.



Dana talks of getting a place or living with her son, yet she feels "I have enough money to live on outdoors, but not enough to live indoors. If I could find a sleeping room or a one room apartment I could live indoors. I don't want to get Public Aid or run up any bills." Dana is very unrealistic about the cost of housing and she does not want to pay more than $100 per month in rent.

An incredible number of agencies have been involved with Dana. Since 1983, ES has recorded at least 28 contacts with her, usually in winter when she presents herself to the local police station between midnight and 2 a.m. needing shelter. Agencies were usually unable to get beyond meeting her most immediate needs, and she was occasionally labeled a. "chronically undomiciled agency abuser" due to her lack of cooperation. Health Care for the Homeless (HCH) occasionally houses Dana in a motel for a few days, but she gets fearful of "living alone" and sometimes leaves early. In the last year a state guardian has been appointed for her, a process which took a great deal of time and effort by Health Care for the Homeless. At the same time efforts

were being made to put her in a nursing home. Dana herself refuses this and also does not want to live in senior housing which she perceives as being for old people. Currently, workers from HCH visit her, manage her money by giving her a weekly allowance out of the roughly $320 per month SSI check they accessed for her, monitor her health and provide transportation to shelters. They have in the past arranged to pay for her meals at the Diner. "When her health starts to go, it will probably go fast, and we'll be there to facilitate what must be done."

In short, Dana, who has been diagnosed as paranoid schizoprhenic and possibly slightly mentally retarded, maintains a life on the streets with limited social contacts although she admits to feeling "lonely." Some service providers (eg., HCH) have established a moderately trustful relationship which assists her in maintaining her "home" on the streets, but she has not responded to more extensive interventions due to somewhat unrealistic expectations for housing, paranoia, and fear of institutionalization. Understandably, she refuses to leave the neighborhood she is attached to, in part because she is familiar with the informal and formal resources there and also because she is afraid her sons will not know where to locate her. Over the years Dana has developed effective coping strategies for survival which make it difficult, if not traumatic, to remove her from the streets.

A pattern of adaption to an urban "hunting and gathering" lifestyle is neccessary among those who remain chronically homeless, such that Dana and others like her now appear to prefer this "unreasonable" choice. But the hardships and loneliness were evident in all the women we encountered who maintained the appearance of "bag ladies" and had histories of or exhibited symptoms of mental illness. Among the men we encountered, alcoholism was common. One such man, Reverend George Johnson, who died in a hospital at age 73 after a brief illness and stroke, had lived on the streets for eight years. He was described by his daughter as a "strong" and "determined" man who had "many homes" and for whom "life was exciting." According to his daughter, George's chronic homelessness began after the family

> . . . got burned out. From then on he left and went his separate way. We heard nothing from him at all for at least 8 months. He reappeared, but he must have gotten used to living on the streets by then. Apparently he thought that he had started the fire by his smoking or something.

His wife and daughter had already asked him to leave since he repeatedly threatened violence.

George travelled the city daily with his bag of belongings--"clothes, a radio, shaving kit, and his Bible and other personal stuff"-- tapping into a wide array of informal social resources.

He was friendly with the police who often lent him money. But he was a binge drinker who liked to show off his money. His daughter stated, "he lived for the first of the month when he would go to a whore house, get drunk on one beer and get rolled." He frequently threatened violence as well, and was known to be abusive. He was hard to live with, although his wife was always glad to see him, and he would have been difficult to serve except on his terms. George's daughter felt that George probably preferred to die the way he did, hanging onto what he had, rather than to have ended up in a nursing home. Such chronically homeless individuals are making choices and asserting preferences among very limited alternatives.

A more common kind of coping pattern among the chronic and repeatedly homeless is that of being sometimes housed and sometimes homeless. Even Rev. Johnson was periodically housed by his relatives. We have spoken with other men, who like George Johnson, have lived on the street and had problems with alcohol, but who have expressed strong desires to find a place to live and in many cases, have done so. These individuals will often maintain a residence if given the opportunity and only fall into homelessness when evicted, for example, for drinking habits, psychiatric behaviors, mismanagment of finances, or temporary loss of income (e.g. due to being robbed). Such individuals may be better characterized as "sporadically housed" rather than "repeatedly homeless." The determination and self-organization required to pull themselves out of homelessness is impressive.

A vivid example of inability to cope with housing difficulties which resulted in repeated homelessness is evident in the case of Darlene Miller, a black 71 year old widow with symptoms of paranoia. Darlene often lived with her dependent mentally retarded daughter which most likely also brought her an additional source of income in SSI checks. She had alienated her other daughter who she inappropriately believed to be the head of a gang. Darlene frequently ended up without a place to stay--being evicted, leaving apartments due to her fears and/or mismanaging her finances--either with or without her daughter. ES had occasionally provided her shelter since the early 1980's, a Reverend had befriended and assisted her and other friends had helped her on numerous occassions. She ended up in a series of nursing homes interspersed with episodes of homelessness. Despite her difficulties and psychiatric vulnerability, Darlene repeatedly checked herself out of the nursing homes, trying to take charge of her situation and regain custody of her daughter. The nursing home she lived in at the time of the interview was one she had chosen with the assistance of a friend. Darlene was rather incapable of maintaining an independent housing situation, but nevertheless kept trying in her own feeble yet sometimes effective way to gain control over her and her daughter's lives.

Coping Abilities of the Never Homeless

The quantitative data (Chapter 2) has already shown that on average the never homeless had significantly larger monthly incomes, better social resources, better mental health and significantly less dementia (or other mental health problems) than those who had experienced homelessness. However, the overall "feel" of many housing situations of the ever and never homeless is sometimes remarkably similar. The potential of housing risk is widespread despite the fact that the never homeless have been and are in stable housing situations. It is the quality and context of these situations that are the really pivotal differences between them.

Three overall patterns of never homeless outcomes can be roughly discerned in the qualitative data. One is that some elderly individuals were so vulnerable (due, perhaps, to poor health or mental health) and so accepting of service that they came to the attention of the service network before homelessness was actually experienced. For example a woman confined to a wheelchair who had been living with her husband for many years in an apartment that had been described as being in deplorable conditions came to the immediate attention of service providers when her husband had a stroke and died in the hospital. She was consequently hospitalized for malnutrition and did not did not resist eventual placement in a nursing home. Her dependency on her husband was in some ways transferred to nursing home staff, but not without some sense of loss and suspicions of the nursing home. Her plight had been immediately recognized by the hospital which could quickly mobilize the other service agencies that were already somewhat involved.

A second pattern which emerges is that of individuals who are truly managing for themselves with adequate resources, having, for example, sufficient finances, active informal and/or formal supports and intact mental capabilities. Many of the SRO residents we interviewed fell into this category particularly since this population can take advantage of the unique informal social resources available within that setting (see Chapter 4). We encountered numerous individuals who, although not necessarily assisted by family members, had found help in the form of caring neighbors, landlords and an almost hidden population of caregivers which sometimes take in near strangers. For example, Willie Guenther, a single, 77 year old white man, lives with a family who befriended him after he was physically and financially abused by his girlfriend's sister several years before. When he was released from the hospital after treatment for malnutrition and dehydration, the Holts took him in and "nursed him back to health." ES encountered Willie after the Holts' son was arrested for drugs and tried to convince him that he was being financially exploited. Willie refused service and stayed with the Holts. Despite the fact that he does not have

control of his money, he seems happy there, enjoys playing grandpa to the Holts' younger children and has no plans to leave. Although Willie's coping abilities are not particularly strong on his own and he appears to have been dependent on others much of his adult life (even being taken advantage of). He has *chosen* to be dependent on *informal* rather than on formal resources. In this case, his choice seems to have turned out relatively well and his situation appears to be stable. Without the Holts he would be at high risk, but the reciprocal advantages of their relationship and Willie's fixed income, make him quite secure.

Finally, an equally common pattern was that of individuals who were for a variety of reasons extremely resistant to service and had been able to get by, not always in the best of conditions, on their own. Within this category are also needy individuals at potential risk of slippage should, for instance, their mental capabilities change. Such persons often did not receive service even when they needed and wanted it. This latter category of the never homeless raises additional questions about the conditions under which some of these supposedly better off (ie., not homeless) individuals live. The following represent two such cases: one man who refused service and one woman who would have been receptive to more help than she got.

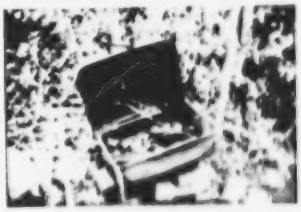
Eugene Fuller: At Risk in His Own Home

Like Josie Hicks, Eugene Fuller, a 78 year old white man, had been living in his own home for over 15 years. He was living with his dog, in a middle income neighborhood when ES was called in to help "a senior living in deplorable conditions with no utilities." Unlike Josie, Eugene was effectively able to refuse services and maintain control over his decision to stay in his home, was never placed in shelter and was never institutionalized.

Eugene had no children and got by with little assistance from those around him. His wife had died over six years ago and neighbors report that he kept their home immaculate, exactly as she left it, for some time. He later had a womanfriend who had since disappeared and he had a brother who was in minimal contact, both of whom he said stole from him.

About 4 years ago, neighbors began to notice changes around the house and a lack of care. Eugene became a "pack rat" and was increasingly "unable to take care of himself." The neighbors began bringing over food and eventually called ES (and YFS) for assistance, who were unable to get him to accept any service. Eugene managed to maintain his existence: he occassionally accepted food and minimal help from neighbors, he ran a generator in his garage for electricity (most likely because the utilities were disconnected), he collected cans for money, he bathed and washed dishes outside with the hose (possibly because of plumbing problems) and would let no one into his home. A neighbor reports that he received meals on wheels at one time, but that he was too proud

to accept "charity." Eventually his health deteriorated and he became more vulnerable--he was hard of hearing, had arthritis and walked with a cane (which was stolen from him). Due to weakness (possibly malnutrition) and falls, he was in and out of hospitals.



This makeshift backyard barbeque was used by a woman whose gas and electricity were disconnected. People without utilities devise creative ways to cope.

In short, Eugene did not become homeless for several reasons. He owned a home, had strong attachments to his house and the memory of his wife, probably had a decent income and lived a reclusive life, stubbornly refusing to let any agencies intervene. However, Eugene's living conditions had become unsafe and apparently unhealthy, obviously complicated by health and possible mental health problems. Though never homeless, he received little or no service, because he was "too proud" to accept help, and probably because he feared dependency on others and the possibility of being put in a nursing home. Even neighbors were able to offer him only minimal help. In the summer of 1988, he was hospitalized and treated for bronchitis, released to his brother, and only 3 days later he was hit by a car while picking up cans. Eugene died struggling to maintain his independence and his home while engaged in one of his survival strategies. Had he survived the accident, it is possible he would have been removed from his house and placed in some kind of institutional care.

Viola Cooper: Alone in a Dreary and Dangerous Apartment

At similar risk, but so far experiencing a less unfortunate outcome, is Viola Cooper, a thin 70 year old black woman who continues to live alone in isolation in her basement apartment. She greeted us in the hallway with a toothless, pleasant smile. Her three room apartment, furnished with odd items of run down furniture, was cluttered, dirty and in poor condition: paint was peeling, pipes were exposed and leaking, there were holes in the ceiling. This apartment, for which she pays $250 of her $490 monthly income, was not much of an improvement over her last apartment where ES found her.

Viola's encounter with ES two years ago was due to a fire. She had just come home from the hospital after 8 days in intensive care for treatment of an infected bite on her face received from a rabid rat. She had been bitten while sleeping in her apartment. After the fire, ES determined that repairs on her apartment were "in process" and "relocation (was) not needed," although followup services record the deplorable conditions she was living in. After the fire, a new male tenant moved in next door, "a big dirty and greasy man who would not scrub out the bathtub," with whom

she had to share the bathroom. When she began to complain, the landlord suggested that she move "because I called the building inspectors and let them in." She tried to move. She found an apartment and paid the deposit and rent, but had no money left to move. She was referred to a private agency by the City, who helped her move and gave her some furniture. However conditions at the new apartment aren't much better. For the first few months she had no running water and a stopped up toilet.

To us Viola maintained a fine sense of humor and appeared to be a warm and tender person. Her apartment was decorated with hand written religious sayings and religious articles. She never had children, but had been married and had worked at a mental hospital for many years. This pleasant woman ended up in her situation in part due to health problems and loss of social supports in her old neighborhood. After a mastectomy in 1972, her husband of 30 years divorced her because "he didn't want to be responsible for the medical bills."

Currently Viola suffers a lot of pain and may have a reccurrance of the cancer, although she has not had a medical exam in 8 years. She admits being lonely and depressed and her eyes teared when she talked about her desire to move into a "decent" place like a retirement center. She also said she wanted to work, babysitting or whatever.

In short, Viola has coped, being mentally intact and resourceful enough to locate another apartment, and well enough to maintain housing. However, the quality of that housing is so poor and Viola so isolated that she is almost as vulnerable as the homeless. Alone, sick, and depressed, her condition is aggravated by the unhealthy conditions under which she lives (rats, leaky pipes and peeling paint). We could not help feeling that if she didn't find a more adequate and sociable living situation soon, she would probably not live long.

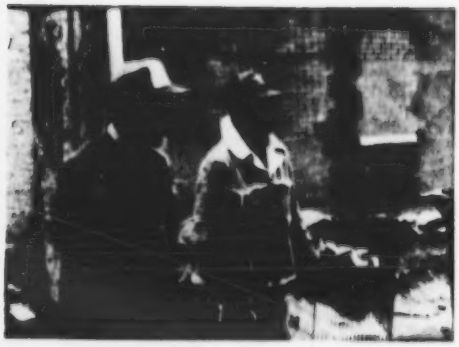
Some Overall Themes

Most of these cases describe individuals who are "difficult to reach" or in some way living on the fringe of generally accepted societal norms, for example, exhibiting reclusive behavior, suffering from alcholism or diminished mental functioning of some kind including dementia, or even sometimes having never married or being childless. Although we have not yet conducted systematic qualitative comparisons, we have identified some very general (and tentative) themes concerning coping capacities and housing difficulties.

Individuals experiencing a single, usually short term episode of homelessness exhibit two overall coping patterns: capacity to recover and regain their home or slippage into alternative paths of "pseudo homelessness" like insitutionalization. Some individuals who come from

Some reclusive and private people are found by the police wandering, or are lost or confused. Vulnerable to accidents and crimes, this woman, who is deaf and speaks little English, is sometimes assisted by vigilant neighbors.

Margaret preferred the independence of living in different SROs, and her fear of being poisoned kept her moving frequently.



Collecting cans is part of the daily routine of many men, whether they live in shelters, SROs or other low rent places.

Basement apartments, such as Viola Cooper's, are sometimes poorly maintained.

relatively long term stable housing situations, like Lawrence, rather quickly resort to their own resources, informal or formal social supports, to pull them out of what was a temporary crisis and thus regain stable housing. The period of recovery varies, depending on how much formal or informal assistance the individual was able to muster or accept and how well they were able to manage their own affairs. Other's like Margaret can display a housing pattern of instability (much like Darlene's) yet because they are independent, are able to fend for themselves and can seek out new housing independently, still do not end up on the streets, at least not permanently. Others, like Josie Hicks, are virtually incapable of maintaining adequate housing or caring for themselves, usually because of dementia or other mental problems or deficits. In most instances, at least with very old or frail people, a lack of coping abilities results in hospitalization and/or institutionalization.

In contrast, chronically homeless individuals illustrate capacity to implement creative survival strategies on the streets by maximizing available informal and "free" formal resources. The chronically homeless, contrary to popular belief, can display strong attachments to places, things (belongings) or people. At the same time, they may either enjoy or find necessary the freedoms of wandering and being outside, certainly in comparison to the alternatives they fear, the threat of being put into a shelter, nursing home, or institution that would deny such freedom. Thus some work very hard at avoiding that possibility. In many ways such individuals can establish a sense of "home" on the streets and have means of maintaining their privacy and autonomy by being "uncooperative" with agencies. At the same time the chronic homeless often experience alienation from family members and will express desires to live somewhere.

Their abilities to maintain both informal and formal helping networks vary. For example, while George was able to maintain a fairly extensive part time informal network of relatives and friends to help him maintain his lifestyle, Dana was "lonely" and wished she could spend more time with her sons. Dana, who was the most resistent to service, was most actively sought out for intervention, possibly because she was a woman (Bachrach, 1988; Kutza, 1987). Those who appear to be chronically homeless in that they are repeatedly homeless, like Darlene, may lack some of the coping capacities and abilities to resist intervention that the street people have. Some of these individuals may not live on the streets for such long periods of time in part because they have been less able or willing to cope with its rigors.

The cases of elderly individuals who were homeless are not always so different in general characteristics from those who were never homeless. In particular, Eugene's situation bears striking resemblance to Josie's except that agencies were unable to penetrate the wall of "uncooperativeness" and independence he struggled to maintain. Although both Josie and Eugene

suffered from dementia, Eugene was better able to maintain his autonomy, possibly due to his better income, reclusive lifestyle and the learned skills of independence associated with being male in our society. Viola, although she has remained housed, certainly lacks the ammenities associated with having a "home." But Willie, who appears to have one of the better living situations, ironically seems the least able to fend for himself. To compensate, he has allowed his informal supports to develop and take over in a way that Eugene and others probably never could.

Whether homeless or not, most individuals' housing histories were characterized by stability at some point in their adult lives, particularly those who were homeless only once or never. Even individuals living on the streets might be characterized as having stable residences because they have established regular neighborhood hangouts and routines, Dana in particular. An outstanding theme contributing to instability or risk in individuals' housing histories is that of devastating loss: loss of a spouse or caregiver, a house, a job, income or services, or other basic necessities. Whether such losses are multiple and compounding, they profoundly disrupt an already vulnerable older person's environment. The nature and extent of such losses are varied, but they are inextricably related with poverty and cognitive deficits.

Summary

If still living, virtually all of the elderly persons described above continue to live at substantial personal risk, whether or not they have been or are currently homeless and whether or not they are currently in an acceptable living situation. Even if housed, the elderly can be living in a "near homeless" or "subminimally housed" (Douglass, 1988; Ovrebo, Minkler and Liljestrand 1984) state, sheltered but with little quality, hope or meaning in their lives even in their own "homes."

Several of the persons discussed above struggled awkwardly but admirably to maintain their independence and avoid insitutionalization and even hospitalization, by opting for the risks of poor health, poor housing and even death--hardly "choices" people freely choose. That they take such risks indicates that for many individuals, independence and autonomy of choice have as much to do with having a "home" as does being sheltered. In cases where elderly individuals struggle to maintain their independence against all odds, it is tragic that agencies of government are unable to prevent traumatic situations such as the loss or deterioration of a home.

Without more systematic qualitative analysis we hesitate to generalize about types of coping patterns. However, the varying coping abilities of individuals with housing difficulties within the context of other problems begins to suggest that there may well be coping patterns associated more

frequently with the hard to reach homeless and those in deplorable housing conditions. For some, any crisis or change in the status of their resources can trigger a slippage into either one of these equally devastating states.

CHAPTER 4. SRO HOTELS: THE EFFECTS OF A SHRINKING HOUSING RESOURCE ON OLDER COMMUNITIES

Single Room Occupancy (SRO) hotels are one of the most affordable types of housing which has traditionally accomodated single inner city poor people. The Department of Housing and Urban Development (HUD) describes SRO's as "partial rooms" lacking complete and private kitchens and/or plumbing facilities and housed within buildings of at least 12 similar units (Haley, Pearson and Hull, 1982). Lawton and Hoover estimated in 1981 that approximately 130,000 (about .6% of) elderly heads of families live in hotels. About two-thirds of these were male and 88% were single. Hoch estimated in 1985 that Chicago had over 11,500 units of such housing and that approximately 10% of these were occupied by persons over age 65.

SRO housing in Chicago is limited and fragile, however. The Hoch study (1985) estimated that approximately 1,000 units of such housing were being lost per year due to conversions, demolitions, and gentrification. Such loss correlates strongly with the growth of homelessness all over the U.S. Kasinitz (1984, p. 10) shows that loss of SRO housing resulted from gentrification and that this erosion correlates directly with growth of the population living in shelters for the homeless. Baxter & Hopper (1981) and the Vera Institute of Justice (1981) both document the extent to which shelter users had been displaced from more established rooming houses and SROs. Rousseau (1981) notes that shopping bag ladies live intermittantly in SRO hotels. Kasinitz notes (p. 11-12) how in city after city studies have confirmed how important SRO housing *used to be* to those who are now homeless, while Hoch and Slayton (1989) draw this conclusion very directly for Chicago. Erosion of SRO housing appears to have very direct consequences for poor elderly persons.

The SRO interview sample in this study was drawn primarily to be a comparison group of similarly situated poor persons living alone, since over 80% of the ES clients to be interviewed were living alone at the time of the emergency and about one-quarter were living in SROs or rooming houses. SRO residents were assumed to be similar enough to the ES clients to have experienced similar threats to their housing stability. In the course of finding and interviewing this comparison sample of older SRO residents, we learned much about the importance and adequacy of SROs as a housing alternative for older Chicagoans.

Living in SRO hotels has been simultaneously underrated and romanticized. Depending on whose standard one uses, such settings might be viewed anywhere from "private poorhouses . . . without public accountability" (Douglass, 1988; Siegal, 1978) to something wonderful, the last

great bastion of poor man's civility in a gentrifying city (Eckert, 1980; Ehrlich and Ehrlich, 1982; Lawton, 1980; Minkler & Ovrebo, 1985). Other settings, such as rooming houses and boarding houses, flop houses, missions and shelters might also be considered similarly at the bottom of the housing market and less desirable alternatives by today's standards, with older residents at least as poor as those in SROs, but such alternative housing arrangements have even more variable characteristics than SROs. Most are unlicensed, unregulated and consequently difficult to identify. The SRO hotels in Chicago, on the other hand, are easily identifiable because of special city licensing and code enforcement accountability and because of their need to maintain telephone listings and advertise.

In the gerontological literature, SROs have been widely recognized as socially supportive, convenient and reasonably priced housing alternatives for seniors (Cohen & Sokolovsky, 1980) Minkler and Ovrebo (1985) note that they are the most affordable, least restricted form of houisng available to those who cannot obtain other forms, whether because of poverty or because they are viewed as "undesireable tenants." Older residents acknowledge the benefits of their location near central parts of the city, convenience to services and amenities, privacy and social contacts. They are chosen in a free market by seniors of limited means who cannot or would not choose other alternatives in the marketplace.

SROs appear to sustain important informal helping networks (Hoch and Hemens, 1988) and social systems (Ekert, 1980). They offer these strengths through an informal community highly respectful of personal privacy--apparently in ways different from formal housing complexes, organized retirement communities, trailer parks or public housing. In allowing and even facilitating natural social networks, informal help as well as accessibility to formal services, these informal systems both reflect and form an important part of the social organization of cities. Traditionally utilized by the seasonally unemployed, the addicted, and the mentally handicapped, as well as the elderly poor, and located in the downtown, skid row and red light districts, SROs have provided shelter as well as considerable tolerance for deviant individuals and activities. They are ermissive and accepting of behavior disapproved by the larger society, but cleanliness, newness, and maintenance are less in evidence. Norms of respect for privacy and an assumption of autonomy continue to prevail. Community functions that take place in city streets, like surveilance and emergency response, socialization of newcomers, and barter are critical (and yet only possible) in an environment so dense and visible, yet impersonal. (Jacobs 1970) On the other hand, the "social organization" of such roles and communities, based upon limited personal knowledge and presumed independence, is not always

approved of by wider society. This very freedom with its opportunity for personal choices is that which is typically denied by the regimentation inherent in long term care facilities today. (Kane and Kane, 1989) This freedom is precisely what old people fear losing if they have to relocate.

Finally, SROs play an important role for governments as an alternative to more structured, formalized, and expensive housing settings, espcially in providing for the very limited, marginal or dependent in society. While SRO housing has been inadequately acknowledged as a resource, it has been widely exploited by governments in times of necessity, as in the dumping from state hospitals that occurred in the 1960s and 70s, and as contractual big city "welfare hotels" for homeless families in the 1980s. Today, the reduced supply of SROs are playing an increasingly important role to cities facing housing shortage crises and to governments at all levels looking for market mechanisms to solve their problems. Governments charged with responding to such urgencies within severe economic limits hope for solutions offering decency. Differing city agencies, responsible for different problems, struggle among each other to trade off their respective preoccupations with access, adequacy, and cost in the implementation of their respective functions (Hoch & Slayton, 1989; Kantor, 1988; Peterson, 1981). Production of housing stock and the imposition of standards of quality remain perplexing in the meeting of overall city needs.

Research Objectives

Given this current salience of low-income housing, it was felt that an update of our understanding of the value of SRO housing to the elderly in Chicago and relative to other poor elderly who had experienced an emergency would be particularlly useful. In doing so, this study started with valuable findings from Hoch's study four years before.

Hoch (1985) studied 18 hotels selected to represent 115 low-rent SRO hotels in Chicago (of a universe of approximately 250) which were identified as buildings providing a 24 hour desk clerk or a switchboard at no extra charge, units with shared baths and units with kitchenettes. These represented 10,541 out of an estimated 12,500 units in the city. His data revealed that 10% of SRO residents were 65 years of age or older, that 80% were male, and that 82% lived alone. While hotel residents were more transient than other Americans, still half the residents had lived there more than two years and 29% had lived there four years or more. Using this information as a base, this chapter seeks to identify trends that might be affecting the elderly.

A second objective was to examine hotels in three specific locales where stock is threatened

to identify older residents' options and preferences should this housing be lost.

A third objective is addressed in Chapter 5. Through the eyes of residents and managers, we describe older SRO residents' lifestyles and needs, noting critical features of social and economic life in hotels that, if strengthened, would improve residents' access to needed services.

Sample Selection

The survey and interviews were conducted with hotel staff and residents at 27 hotels. The basic criteria for these contacts were to obtain enough information to select the senior resident interview sample, but also to provide a city-wide cross-sectional sample of hotels in which seniors live. Three areas were especially targeted for data collection because of the density of SROs, including Uptown, the South Loop, and the area near the proposed stadium development on the Westside. In addition, however, it was important to have a sampling somewhat comparable to the Emergency Service sample, particularly in terms of race. For this reason, the Grand Boulevard area was also targeted. The eight city neighborhoods from which formal interviews were finally done are shown on Table 4.1 (see also map, Figure 4.1).

Since the 18 hotels in the 1985 study were already a stratified representative sample, all but one were recontacted. However, full assessments were conducted at only twelve of these for a variety of reasons. Six were not surveyed more extensively because two were quite small, another would not permit female interviewers to enter, and three on the South Side were so "drug infested" or involved with criminal activity as to be too dangerous. (This area had presented difficult access problems in the 1985 study also.) Resident interviews in these areas were supplemented with interviews at other hotels in these same neighborhoods.

In addition to these 18 hotels, 9 more hotel assessments were completed for a total of 27, allowing a broad view of currently operating SROs across the city. Three hotels where a feeling of stability and social support was particularly evident were studied in some depth. At these, in addition to the resident interviews described above, a short questionnaire was gathered from about 40 of the older residents. One of these hotels is in particular danger of closure because of city plans to redevelop the Westside Stadium area. Finally, we describe the impact of a recent fire at another hotel to illustrate the insidious disappearance of housing resources and emergence of casualties.

Some Comparisons of Our Findings with Hoch's 1985 Study of SROs

The 27 hotel assessments, together with the SRO resident interviews reveal a lot about the desirability of SROs as living environments for older people in Chicago, particularly the ways in which seniors and hotels cope with each other. Here we report on what appears to be happening to seniors as SRO housing becomes more difficult to find. We note the various pressures caused by certain neighborhood locations, rent increases, and the prevalence of seniors in certain hotels.

Seniors' Use of SROs as Scarcity Increases

Hoch noted in 1985 that only about 10% of SRO residents were age 65 or older. This overall proportion appears to be holding steady, although we found older residents somewhat clustered at certain hotels. In one-sixth of the hotels at least half of the residents were over 50, and in 40% of the hotels at least 25% of the residents were over 50. In our larger set of 27 hotels we found a slightly larger proportion of residents age 65 and over, ranging from 5 to 30% with an average of 17.8%, but this reflects our selection bias.

Older residents tend to be the long term ones. In the 1985 study half of the SRO residents had lived in their present hotel for two years or more, and 29% had lived there 4 years or more. In our sample, 86% of residents over age 50 had lived there two years or more and 76% had lived there four years or more. They had an average residence of 8.3 years at the present hotel and 27% had lived at their present hotel for 15 years or more! In a few cases these long term residents were also long term employees of the hotel. These older residents usually reported no plans or desires to move.

Residents over 50 are relatively young. The mean age of the our sample was 70, suggesting there are many pressures on older SRO residents that preclude either their moving to or remaining at SROs. In the period between ages 50 and 65, most residents apparently die or make some important decisions about relocating. Examination of residents' previous living arrangements suggests that it is not easy to *find* a room in another SRO, especially an affordable SRO in one's own neighborhood. If the previous residence was also an SRO, it usually no longer exists. While most residents had always lived alone, many had previously lived with their own parents or siblings, and another large group had previously lived with their children. The independence usually required to remain at an SRO, plus the attraction of lower rent in CHA or other subsidized housing when one reaches age 60 appears to encourage a large proportion to

leave.

Examination of the 18 hotels in the 1985 sample today confirms that study's projection that SRO housing in Chicago is disappearing. Since 1985 one of these 18 hotels (one in the Grand Boulevard) area has closed. Two others in that same area have declined in quality to the point that drug trade and prostitution made them too dangerous for our interviewers to enter. (While such environments are obviously risky for older residents, we were told that some seniors continue to live in these hotels.) Other areas have also experienced losses of hotels, most notably the South and West Loop areas. Many hotels in these areas have had rent increases that make them prohibitive for persons on fixed incomes. While the proportion of rooms devoted to transient versus permanent rooms sometimes fluctuate, the number of rooms available per building seems to have remained about the same.

Rising Rents

The 1985 study noted that on average residents who paid by the month paid $161. Among these 18 hotels only three years later, we found rents ranging from $115-442 and averaging about $250. Of the 30 residents we interviewed, rents range from $160 to $366, with an average of $247. This rent level represents from 11 to 75% of the income of the residents we interviewed, with the average resident paying 47% of his income for rent. (The large variation in this range is due to the great variance in incomes of residents who are employed.) The three couples in this sample spend, on average, only 35% of their incomes for rent because of the economy of pooling their resources.

This 56% increase in hotel rents in the past three years, far in excess of inflation, is partly explained by the shrinking supply of SRO units which has increased demand. On the other hand, since seniors tend to be long term renters and considered desirable tenants for whom owners more frequently allow a break or two, the rent increase has probably been even greater for younger and newer residents than for seniors.

There is substantial variation in rents paid by neighborhood. The South Loop rents are now particularly high as demolitions and gentrification creep into that area. Because of gentrification, many hotels there and on the Near North side, Near West, Greektown, and Lakeview areas no longer serve low income people at all. Even hotels which remain relatively inexpensive (under $220) have experienced rent increases of around 30%, which means that some of their previous tenants can no long afford them. For example, we found only one resident over age 50 on General Assistance, which pays only $154 per month. He supplements his $170 rent by collecting

bottles, although such earnings are technically illegal.

Price is not the only feature that deters seniors from settling in SROs, however. Reduced supply and increased demand has meant that operators can be more choosey about who they rent to. Marginally functioning and even disabled persons are somewhat less "desireable" than they were before.

Variation in Demographics and Prevalence of Seniors

One of the most lauded features of SRO living is that it naturally integrates persons with varying needs and characteristics, particularly on the basis of age and income. It is this mix and the informal barter that occurs naturally which strengthens the social setting (Hoch, 1985). Some operators, however, clearly prefer to have only employed residents, while at other hotels "naturally occurring retirement communities" have developed as seniors have remained in buildings with the right mix of amenities, rents and management attitudes. Often particular floors, and sometimes whole buildings, come to be occupied by seniors. While SROs continue to be occupied largely by men, women appear to be more likely to share a room than to rent one in their own names. Among the older residents, we found one in nine rooms occupied by a couple.

Prospects: Three Specific Locales Where Stock is Threatened

Racially, the Uptown area is largely white, and prejudice and discrimination are evident in that several hotels still have no non-white residents. While most hotels are very run down and occupied by non-working, alcoholic or otherwise disabled residents, the edges of this neighborhood are gradually gentrifying. Many hotels specialize in some way in providing either board and care or an otherwise sheltered environment for the area's many residents with disabilities. (Uptown has been known since the mid-1960s as the neighborhood into which several Illinois state mental hospitals "dumped" patients.) Several hotels have direct agency contracts which provide extra services.

The West Stadium area is mostly black, but Near West Side hotels are integrated. The neighborhood, including its hotels, is characterized by long term social networks with a palpable sense of community. Other hotels in the area are occupied largely by black working men. Even if hotels do not close, demand in this area will inevitably increase because of loss of other low income housing in the area. The near West Side has already absorbed some pressure from the West Loop redevelopment of Presidential Towers and the razing of the last hotels on West Madison

Street.

Finally, the South Loop area, which is the most racially mixed (typically white ethnic owners and mostly minority trade), and continues to have the most viable transient hotel trade, is changing the most rapidly. Closest to the most recently developed West Loop area and Presidential Towers, it appears to have absorbed the most SRO residents displaced from West Madison Street. Hotel rents in the South Loop are creeping up, and structural and cosmetic improvements are in evidence at many as they seek higher quality clientele. With a few strong exceptions, most hotels have mainly transient trade, and little sense of community. Ferns and brass have replaced the peeling paint in several first floor bars. A few notable hotels that are in the way of large scale downtown development projects or have become visible nuisances are virtually empty and awaiting demolition. Gradually low-income people are being discouraged out of this area by rising rents, although a few older residents are being allowed "hold harmless" tenure.

Incidently, regional pressure has also increased on the South Side around White Sox Park where the Illinois State Sports Facility Authority has bought the entire seven block area of South Armour Square. In the course of our research we stumbled upon the vast relocation of this neighborhood with a population of about 600 people in single and multiple family homes. We estimate from talking with residents that about 100 potentially homeless single men rented in that area. By March 1989 the entire area had been razed and no agency any longer knows where the residents most vulnerable to homelessness have gone.

The Ecology of a Fire: Homelessness in Progress

Seven months after our hotel interviews were completed, at 5 a.m. one chilly morning in March a three alarm fire seared through the New Jackson Hotel located in Greek Town. Like a giant game of bumper pool, first terror, then dislocation, and now permanent uncertainty has descended on a building that has been home to 108 residents for many years.

The Hotel

We had previously interviewed four men at this hotel, one that is remarkably racially and ethnically mixed. Half of the residents are over age 50 and most are men. Many are former skid row alcoholics, disabled to some degree, or on fixed incomes, and many have experienced homelessness at some time in the past.

A four story building, the hotel was built in three separate sections which have been breached and joined by rolling floors and meandering stairways. Built in about 1878, the New Jackson is believed to be the oldest continuously operating hotel in Chicago. The owners told us it used to house many vaudeville actors who worked downtown, and they have a 1900 vintage photograph of the original hotel from the Chicago Historical Society which they hoped to enlarge and hang in the lobby. The lobby, now decorated with faded technicolor scenes of Florida beaches, is regularly occupied by about a half dozen men who hang around the front desk attendant and the bellman and their blaring little TV. Others sit outside on Jackson street on nice days, or tip a bottle in the adjacent parking lot, to the east of which is the Kennedy Expressway, and beyond this the downtown Loop. The front of the hotel at Jackson and Halsted Streets, is one of the busiest, most commercial, and most prosperous areas on the west side. Three businesses, a Greek fast food restarant, a barber shop and a bar are on the Halsted side of the main floor of the hotel. Six blocks to the West is the proposed site of a new football stadium for the Chicago Bears. Two blocks to the South is the University of Illinois campus. The New Jackson, a strong and stable, but quiet community of low-income people, is in a classic location to be threatened by the very vitality and increasing affluence of its surrounding neighborhood.

The tenants here give new meaning to "long term" residence. A handful of rooms are for transients, but over half the residents have lived here longer than seven years, and at least fifteen are over age 65. Several employees live here. The hotel's maids have worked here 30 to 35 years. One bellman, who lived and worked here for 30 years, was recently hospitalized for lung cancer. Another started working here at age 17, and except for the time he was in the service, he has lived here for 50 years.

A Jewish family has owned the New Jackson since 1952 and day to day operation is managed by a father and son. Young Mr. Schlinn, who grew up in the hotel business, has a degree from Northwestern University and is now in his late 30s. Both men know many personal details about their residents and express genuine concern for their needs; while accepting of problems, they are intolerant of behavior that threatens other residents or property. They worry that the rent increases from $160 to $210 in the past 8 years now makes residence impossible for people on Public Aid, and difficult for Social Security recipients. Their daily presence at the hotel is partly required by the frailty of its infrastucture. They put a new roof on the building last summer, and recently replaced a boiler.

The New Jackson Hotel in summer 1988.

The New Jackson after the fire in March 1989.

The Fire

The fire started in the third floor room of a transient guest in the west section of the hotel. We were told this resident was an alcoholic who smoked marijuana and that the fire started in a pile of debris near a wall in his room, although he was not there at the time. The official fire report said it was caused by faulty wiring. The fire spread quickly to the fourth floor and then into the ceiling area where it smoldered for quite some time destroying a major part of the roof. In addition to fire and smoke damage, the hotel sustained considerable water damage and damage to walls from chopping required to control the fire.

The entire hotel was evacuated and early news reports were that 70 persons had been displaced. One man was hospitalized briefly for smoke inhalation, but no other injuries were reported. Emergency service staff from the American Red Cross and the Department of Human Services arrived on the scene and, because of the cold, arranged for two CTA buses in which the displaced persons could sit while relocation arrangements were made. Both Red Cross and DHS provided hot drinks, food, and blankets.

Processing of the fire victims took all day. Some from rooms that were less damaged were allowed to reenter the hotel and get a few belongings, which they carried out in shopping bags. Eventually the buses transported all the displaced residents to the Red Cross offices from which they were given food vouchers for McDonalds and shelter vouchers for two nights at local motels. By 6 p.m. 35 persons had been placed and the rest had been allowed to return to their rooms at the New Jackson. The 29 rooms in the damaged section of the building were all determined by the fire chief to be non-inhabitable and this area was closed off.

Thirty-three of the victims were placed at 5 different motels, three on the north side and two on the south. A DHS team took one 80 year old Hispanic man who "was pale and walked real real slow with a cane" to Walgreens to get his medication and then placed him at a congregate care facility; another, a quiet old man with white hair refused to leave the area. He wanted to stay on a cot at the Red Cross building, but this was not allowed. He wandered away.

One man who was placed in a motel had just returned from the hospital the day before the fire. He was dependent upon two oxygen tanks and required the assistance of another man just to move around. Another motel placement was a man in his late 50s with only one leg who maneuvers on crutches.

The Emergency Service list of the persons who were placed in paid accomodations that night is a cross-section typical of low-income housing. Eighty-five percent were men, 45% were black. Ages ranged from 24 to 80, but tended to be be in two groups: half were under 40 and

30% were age 60 or over. Twenty-five percent were listed as employed, but 20% had either no income or income only from Public Aid. Forty percent were on Social Security, either retired or disabled, and the rest were unemployed. The latter group included a 56 year old woman who is laid off from her job as a maid in the Loop and recently had surgery on her feet. She shares her room with her 24 year old daughter and grandbaby.

In addition to those who were placed, several residents relocated themselves with friends or relatives. An Asian medical student who is soon to graduate anyway, will stay with friends. A couple of others, bothered by the commotion, chose to move out.

"Bumper Pool" Begins

On Monday morning when their vouchers ran out after two days, virtually all of the 33 displaced persons who had been in motels returned home to the New Jackson. At this point an intricate kind of bumping process began. A few transient rooms opened right away and were filled. A few other residents were accomodated in rooms that were gradually becoming vacant. The owners asked one unstable mentally ill young man to leave. He will live with relatives, at least for now. A woman in her late 50s, "who is kind of a packrat" and accumulates so much junk that her room is a fire hazard, was also asked to leave and her brother took her in. One man was arrested and jailed when he and a friend were caught by the police stealing TVs from the damaged section of the hotel. The owners asked the friend to move out as well. This shifting will gradually free up some rooms in the still open section of the hotel. The room of the mother and daughter sustained water damage to the ceiling and there was concern that the baby might eat the peeling paint, so they have placed the baby with other relatives.

At the request of the owners, DHS returned Monday afternoon to make "more permanent" temporary shelter arrangements for those the hotel still could not accomodate. Two more older residents were placed at the congregate care facility. In groups of 5 to 8 the rest were placed at various shelters for the homeless, with effort to locate places as nearby as possible. Discomfort with using overnight shelters was widely acknowledged. While several of these displaced persons have been homeless in the past, they are not "homeless types" now, but DHS policy disallows the placing of able bodied people at care facilities or paid permanent housing. Overnight shelters, however, do not permit people to remain in the building during the day; indeed most require that guests vacate by 6 or 7 a.m. and they are not allowed to return until 8 p.m. A placement worker was troubled when he observed, "Paid shelter would be a problem for us because I just have a limited amount; I can't place everyone there. The guy in his late 50s, the amputee on crutches,

had to go to an overnight shelter." A few days later, however, he got another room at the New Jackson.

The DHS coordinator visited the New Jackson five times in the week after the fire, and provided the owner with a useful directory of shelters and other social services. Each time a room opens up Mr. Schlinn gives priority to one of the shelter residents. A week after the fire, one of the older black men returned asking for his room back. He had paid up his rent through the next month and he felt he was owed a place to stay. Saying he will look for a room at another hotel, he was given a refund. It was noticed, however, that he needed the money now as he was broke. Most residents have let the owners keep their paid up rents with the hope that they can resecure another room soon. All of the staff are back now and Mr. Schlinn hopes to accomodate every one that has approached him for a room in the next few weeks. A number are not coming back, however.

Prospects

A week after the fire, the damaged section of the hotel remains sealed off. Hotel staff are clearing out damaged carpet and debris. While the structure appears to be solid, the material and style of its construction cannot be replaced. Water damage to all floors and ceilings is extensive, as is damage to walls and ceilings where venting holes were made; crews are estimating the cost of replacing the entire roof and of cleaning up the business establishments on the first floor, so they can be reopened as soon as possible.

The owners indicate that the building has been "self-insured" ever since the insurance rates went so high that they had to make a choice between paying them or staying open. "Self-insured" means they have no insurance at all (but have to show proof of self insurability), which describes the situation of virtually all SRO hotels. Almost no one can get replacement insurance, or even liability insurance usually, because of the risks involved. "It's like trying to get medical insurance for a 90 year old man with a heart condition." And without insurance, they can't get loans for rehabbing. It's a vicious downward cycle.

If repairs are made, each and every one will have to be financed from operating revenues. Each will be prioritized against the income producing capacity of the investment. The roof will be first, then the businesses, and hopefully the rooms. The owners could quickly be forced to raise rents. If its feasible, they definitely want to stay, but nothing is certain at the moment.

They could be forced to sell, but they are painfully aware that selling would be the end of this hotel. "No one looks at a building like this and says 'I want to buy an SRO.'" There is just not

enough money in it. But many developers could become interested in this property, not for the value of the hotel but because of the obvious value of its location. There is a new Quality Inn just to the North. Plans for the West Stadium area have been publicized and private plans for the area are surely known to those who recognize opportunities. Information is worth money, and since this area is definitely scheduled to be redeveloped, information about it is presumably worth a lot of money. If the building is sold, "everyone" will make money, and there is surely strong community interest in improving the area.

One person we interviewed commented about the West Stadium area, "There will be more fires in the area. You watch the newspaper for the next year, that area especially, and see where the fires occur. There was another one not long ago. . . It's not really explainable, but things have a way of just happening. You see it in Uptown now too, on Kenmore Avenue, on the edges of the area as development moves in and poor people get crowded out."

Aside from the business and the economic development interests of the many "big people" in the area and the hotel itself, one question remains. What will happen to these residents deeply attached to this corner and this hotel? They have been coming back all week, and they will continue to come back, even if forced to stay at the shelters in the area as they are doing now. Why? This hotel is home. It is familiar and it represents the most meaningful attachment in most of their lives. It is also safe, and private, and so far it is cheap. It would be conservative to say, that to many this hotel is life itself with everything that can be expected from it at this time. Besides being a tragedy for its residents, its loss would be wasteful to all the community. The city will continue to pay a terrible price for such housing loss until effective policies for preservation and creation of more low-income housing are adopted.

Whatever happens next, the old timers at the New Jackson will probably be the last to know.

Summary

The disappearance of affordable and socially supportive SROs continues in Chicago because of pressures upon neighborhoods toward redevelopment and because of the city's complete lack of a strategy or incentives for preserving and improving them. The loss of this very valuable housing resource has contributed substantially to homelessness and unnecessary institutionalization of the elderly. The human terms of this loss will be illustrated in the next chapter as we explore the needs of older people which are met by SROs.

CHAPTER 5: SRO HOTELS: HOW THEY MEET THE NEEDS OF OLDER PERSONS

In one sense older residents of SROs are survivors who have remained here for some very specific reasons. This chapter explores what older SRO residents told us about their needs and about what is important in their daily lives--the essential reasons they continue to live in hotels. Most of them express little interest in relocating, and would not, except for the pressure just described in Chapter 4.

In Chapter 2 we noted that our sample of SRO residents has more resources than the sample of Emergency Service clients. Although SRO residents are somewhat younger, their relative "youth" does not explain this difference, and they generally are neither healthy nor wealthy. At least half of those over age 65 retired before their 65th birthdays, because of either disability, health problems or involuntary termination of employment. Several among the 50-65 age group are already retired non-voluntarily. Of all the SRO residents we surveyed, 17% are still working, 23% are disabled, and 57% are retired and receiving Social Security. At least 10% are working to supplement their fixed incomes while at least another 10% are receiving supplementary pensions or have some investment income. At least 33% are also receiving Veterans benefits, but typically only medical care.

In considering the needs and resources of such residents, we started by talking with hotel staffs, who had difficulty estimating residents' ages. (Desk clerks guessed at ages but rarely knew them exactly. Often the estimate of the proportion of residents over age 50 was quite different from the number of persons that could actually be identified.) The estimates of need that follow, then, are "soft" data, simply reflecting staff's thoughts about what "older" residents need. Many positive dimensions of SRO living are identified, as are features of hotel living that could be enhanced further. Many resources available here involve the social milieu or feeling of community. By building upon such strengths and improving access to formal services, the quality of lives of older persons in SROs could be improved.

The following analysis discusses, first, reasons that hotel personnel mention for seeking or discouraging residence by older people, and then the reasons seniors give for living in hotels. We observed that the existence of long term casual relationships is overwhelmingly important in these choices. However, alleviation of physical barriers, access to formal services, and meeting of personal needs could certainly help seniors in hotels to "age in place" with greater ease and dignity.

Why SRO Managers Seek (and Avoid) Senior Residents

Hotel managers repeatedly told us that seniors are very desirable residents, because they have regular incomes, pay their rents on time, and are quieter and less troublesome than other residents. Indeed, several managers mentioned they would like to know advertising channels through which they could reach more potential senior tenants. These tend to be at hotels that currently have unreliable tenants that they hope to evict, such as drug pushers, welfare mothers, and prostitutes. Some that "specialized," renting almost exclusively to seniors and offering reasonable rents, however, still have difficulty advertising their availability.

Still, some hotels try to rent only to working people and do not seek or even want older residents. These include hotels "going upscale" and undertaking renovations, as well as those in working class neighborhoods where male residents all tend to work in the same industries. Others don't take "handicapped" people, sometimes because of building barriers, such as a few stairs for wheelchairs or lack of an elevator. More than one hotel manager observed, "We would like to take more seniors, but we can't modify the building to meet city standards." In a typical hotel, seniors are all on the fourth floor and the management is planning to move them all to the second because of fire regulations.

Other hotel staff noted, "We don't take mental cases"--usually because of some bad experience. Staff sometimes doesn't want people hanging around the building all day either, robbing, bothering, or frightening others. The greatest concern is expressed about "unpredictable" people who "might go off." The observant manager can be made highly anxious by this if he feels that he is left holding the bag by some agency that placed someone who is not stable. "If they function OK, I am willing to help, but I have some now who really don't belong on the streets," as opposed to being in an institution.

The Saturday morning of our visit to another hotel there had been a dramatic incident. "This guy who was just out of the psych hospital went crazy. He apparently started shooting a gun out of his window or off the fire escape. He was manic depressive, about 40. He had only been here a week, had moved over here from (a men's

The three rooms in this "cul de sac" at the end of a hallway are hidden from public view and consequently quite dangerous.

hotel); he was too rowdy over there." An elevator full of cops had all gone up to get him, which created a lot of excitement.

Safety is a big concern. One hotel manager noted: "The neighborhood isn't really safe, especially for frail people, with gangs and crime and all. People hanging around are grown men, also kids. . . You wouldn't stand a chance if they took your purse." Another noted: "Older people are vulnerable to muggings in this neighborhood" (This small 40 unit building at one point had a resident referred to as 'the stabber' who was arrested after murdering someone right out front.)

Finally, some of the more expensive hotels noted that, "Public Aid and SSI recipients couldn't afford to live here. After they pay rent ($260) they'd have only $60 or $70 left for food, and everything else."

Why and How Some Are Urged to Leave

A hotel might ask one or many older residents to move out for a wide variety of reasons. This occurs most frequently when the building is sold and the rents are raised. The new management, having no relationship with the "oldtimers," offers no special concessions for the difficulties a move would create for these older tenants. Continuously operated hotels tend to give more consideration to long term residents.

Indeed, while some have more, most SRO buildings have just a few elderly residents, ones that have resided there for even 20 to 30 years. These often are "characters," people that other residents tend to look out for. Some are reclusive and rarely leave the building, others are treated almost like "pets" by the management and other residents. Some have become the "institutional memory" of their neighborhood and their building, a repository of historical information. Most older residents, however, appear to contribute as much as they gain to the social fabric and sense of community of the setting, such that their presence is valued even as their needs increase.

Within this circumstance, however, some elderly residents may come to require too much daily care or monitoring. In other cases, incontinence, garbage accumulation, or pets might become insurmountable problems unless there is a personal caregiver who helps clean up. To the hotel, there is danger of offending others in adjacent rooms. It appears that many hotels can easily manage one or two residents who require a lot of looking after, but if the building has too many elders needing care, the manager, maid and other residents may simply burn out.

The surest way to be evicted is failure to pay rent. (Many hotels guard against this by holding Social Security and other newly delivered checks at the desk, cashing them for free, and even holding residents' cash in the office safe.) Older residents without a fixed income or who cash

their own checks, the very transient, and those without routines, are in greatest danger of eviction because of not paying rent on time.

Finally, those who irritate or bother the management, hotel staff, or other residents while offering no recompence run the risk of eviction if their needs become greater. These irritants might include things like misuse of hotel property, forgetting their keys, nakedness in the hallways, or abusing drugs or alcohol in public. Others are not likely to show consideration for those who show no sign of reciprocating.

The procedure of eviction, while actually a legally prescribed one, is still effected quite efficiently by simply locking residents out or confiscating their belongings. Such measures are imposed usually when the rent is due and the tenant has already shown a tendency to not pay on time. While some operators admit having trouble enforcing rent payment schedules, most are very clear about their expectations and the sanctions they impose for lateness and non-payment. They are not in the business to run a charity, and all claim to have very fair rules which they enforce evenly. Several described having evicted people (rarely older residents, however) who then slept "out back near the alley" or in the back of a nearby bar where they got handouts, or otherwise "lived homeless" in the neighborhood for some time.

Clearly, then, having employment, good health, income, ability to protect oneself, lack of disabilities, and independence are all assets for an older person hoping to move into or remain in an SRO. And, in fact, most do appear to remain unless forced out by rising rents.

Why and How Seniors Remain in SROs Despite Increasing Needs

Why they stay. Our interviewers left a short survey at several hotels asking residents their ages and the reasons they chose to live at a hotel. Reasons most often noted include privacy and quiet, transportation and convenience, and affordable price. Others comment on the safety in the hotel, even if the outside neighborhood is not so safe. Most hotels go to a lot of trouble to secure the premises inside. Most are close to necessities, especially grocery stores, bars, and laundromats and a bus route which allows ease in geting downtown to the Loop. "Being left alone" and "the people are OK" are also mentioned. Obviously familiarity, habit and routine are terribly important to persons with limited mobility. Knowing the neighborhood, especially the merchants, friends, neighbors on the street and the neighbors in the building are also important.

Residents who have considered moving out usually mention that living in a Chicago Housing Authority (CHA) senior building would be cheaper. Those thinking about this option usually are not quite 60 years old yet, know that they would need to be on a waiting list for a long time, and

several are on a waiting list already. Those interested are aware that CHA offers very affordable rent and a greater sense of security, especially in terms of personal safety. Several considering this also mention family members who have advised them to move either to retirement homes or to CHA.

Several emphatically said that they would *not* move to "no senior building." They do not like the idea of being surrounded by old people and of not being able to do exactly what they want, e.g. to drink, hang out, or "watch the young ladies." Among those who do not move, there are strong reasons for not doing so.

How they stay. Most people over 60, even when poor and living alone, manage quite nicely without help in settings like SROs. This is the key reason most can remain, since many hotel managers clearly state, "We treat everyone alike. It is a good building for seniors as long as they are able to care for themselves. Otherwise we don't have any special help available." Or, "They need to be independent, as no social and health services are available." Clearly, most older residents neither perceive they need services, nor use them, and hotel managers insist on this independence as a general rule.

Many times, however, we find that seniors remain as they get older, only because people in the building, management as well as residents, like them so much and provide vital but incidental help. Long term residents as well as newcomers tend to "watch out for each other." Solid relationships have grown up over many years together through the familiarity and routine of day to day encounters. Helping out is convenient, as well as civil.

Occasionally meals on wheels or visiting nurses come in, but normally only when a resident has the resources to pay for this. Typically only well to do residents, or those who qualify for Medicare-covered post-hospital assistance, or those who qualify for something special, such as veterans benefits, are getting any formal services at all.

More often than not, staff in the building--the owner, manager or desk clerk, but also the maid, bell man, superintendant, custodian, or security guard--provide what assistance there is, helping out with everything from incidentals to personal care. In hotels that still have them, the maids are especially important in providing personal care, laundering clothing and bed linens, and cleaning floors, bathrooms, and cooking areas. Occasionally a maid does a great deal, though usually with extra compensation from the resident and only if she really likes the individual. Most of the poorest hotels, however, do not have maids or provide linens.

The elder is also secure who has a "special" friend, usually a roommate, who will help out

with personal care. Men tend to receive more help in this way, as lots of girlfriends help out even if they only visit intermittantly.

Occasionally a resident is especially good at something and thus valued by the management. For example, one older white man was the plumber at a hotel with mostly black residents, although his vision was very poor and, according to others in the building, "he can't tell a nut from a bolt." This building has a new owner, lots of problems, and this plumber apparently knows every pipe in this very old building by heart. Another resident we heard of had such a "vile mouth" that whenever the lobby gets overcrowded or there is danger of a fight breaking out, the desk clerk asks her to come down. Her very presence as she talks to herself and rants at unseen voices is effective in quickly dispersing even a threatening crowd.

Since privacy and independence are such strong values here, another circumstance in which an elderly resident, even if quite sick, can manage to stay is one in which he or she *insists* upon staying. One is likely to stay who pays rent regularly and threatens a ruckus if the hotel tries to put him or her out. Even if others are extremely worried, residents are not usually "put out" unless management (and other residents, if they are involved) are satisfied that this resident really is willing to move. Hotel staff members sometimes affectionately describe many memorable residents who quietly remained to themselves, or had "come home from the hospital to die." Of a notable example, at one relatively well maintained, 40 unit racially mixed hotel, the researcher's field notes observe:

> One older black woman who was reclusive was found dead during the summer heat wave. She had been defecating on the floor, never took out her trash and was physically ill with emphysema. Her window could not be opened due to the way the phone in her room was hooked up, though the staff believed that, even if she could, she wouldn't have opened it anyway. Her body was apparently never claimed for burial. A nephew was contacted but did not want any involvement.

Such phyical decline is a more regular occurrence at the larger hotels, and more often involves older alcoholic men with chronic untreated medical problems. A particularly observant owner describes his experiences:

> Well, a lot of residents don't take care of themselves. One guy would have lost part of his foot, but as it wound up, he lost his leg (because of gangrene). He had told me he was going to the hospital, but he wasn't. Finally I confronted him. When I lifted the sheet, his foot was literally rotting off. . .
>
> Then I had one of my employees who died here. They're just afraid,

> they've become so acclimated to a building, being on this corner, that they don't want to leave. And they are afraid of the outside world. So, even knowing they could run the risk of being very sick, even dying, they won't go to a doctor or a hospital or a nursing home. I've seen a lot of that over the years.

One SRO resident admitted her fear of medical care to us. This 79 year old woman, who looks at a hospital daily from her window, explained that the last time she went to the hospital, "They said something about cancer, that I have the kind like President Reagan has, colon cancer, but I ain't going to the hospital again." Later she mentioned a dear friend who had had diabetes. "She went to Cook County and she died there." Such residents need care *in place*, and often not very sophisticated care at all. This woman needs her toenails clipped and foot care, also a balanced meal once a day, and laundering of the bed linens--for starters. Her room also needs extermination for insects and vermin.

This couple can see a hospital from their window, but will not go there. She knows she has cancer, but is afraid to return for treatment.

Others have a very real apprehension of being institutionalized. As one hotel owner described it, "I've seen a lot of my residents go to the hospital and never come back. They don't die, they just disappear." Not all go to nursing homes, either. He described two different residents that he later learned were virtually kept prisoners in what he considered deplorable unlicensed boarding houses. "Somebody got him out of the hospital and into this house on the South Side . . . There were three men in a little filthy room, kids running around, cockroaches everywhere, it looked like it should be condemned. They wouldn't allow them to use the phones, get dressed, or leave the building, or anything." Fears of such places, as well as of nursing homes, naturally discourage older residents from calling attention to their infirmities.

Clearly then fear, habit and routine, and lack of knowledge about how to get help and where to go explain residents' unwillingness to go to the hospital. Some hotels call upon the fire department and paramedics when such a situation reaches crisis proportions, but they usually do not. Many such residents simply need home care. Sometimes this might be formal care, but frequently it can be provided decently if not perfectly, by the people already around a hotel. The

weekend desk clerk/custodian at one Uptown hotel described the kind of needs he sees:

> Mr. Smith has a nurse comes in once or twice a week. He is quite sick, has leukemia, and he's just back from the hospital. The maid feeds him every day. He is lonely. He also has a friend who seems to come in daily. People really like him, he is always glad to see you and very pleasant. His wife died just a couple years ago, that's when he moved in here.

The hotel's structure and familiarity make providing such care and handling such situations integral to its routine and its life.

> Another guy died here last week. I had his pills. I often do that for people (take care of their pills), its just decency. He was just out of the hospital. The maid went to his room last week, but then when we didn't see him for a few days, we went up and the guy was dead. So the police came, they sealed up the room.

On the other hand, the old age of the physical structures of hotels, their generally poor condition, and the great expense of building materials that are obsolete, make SROs challenging to maintain, at best. These structural problems present real deterrents to the elderly and disabled.

Building Features That Complicate and Facilitate Daily Living

Because SRO structures are so old, physical barriers like long or treacherous stairways, heavy doors, and poor lighting are simply taken for granted. Like other deterrents, we noticed that most of these impediments can be overcome if the residents and management choose to do so, but they are problems nonetheless. They gradually become problems for older residents.

For example, in one hotel with no elevator all seniors live on the 4th floor. One man with an artificial leg said he usually goes down only once a day, but he manages because others do errands for him. Another man, isolated and quite ill with arthritis, but whose hotel even has an elevator, emphasized the pain and difficulty he has going downstairs just to make a phone call or get groceries. "I have to get up, get dressed, and I'm really too weak to carry anything when I come back."

This "access to the outside" problem is often overcome with just a telephone, sometimes only a house phone. The desk clerk, typically at an antique switchboard, can serve as a life line, by calling certain residents every day and passively monitoring their activity. Unfortunately, telephone deregulation has made most PBX switchboards obsolete for making outside calls. Many

hotels have had to remove the house phones from residents' rooms altogether or institute a charge of 50c or 75c for their use, creating a crucial deterrent for many residents. The phone companies have removed nearly all public telephones from the hallway floors. The man with arthritis told us the effort required keeps him from going to the lobby to use the only pay phone to call the VA Hospital, even when he is in a good deal of pain. Nor would he ask neighbors to perform so personal a task. The lobby phone certainly does not provide the privacy or comfort of the telephone he used to have beside his bed.

The old age of SROs creates another problem. Much of the old equipment does not work or requires continual maintenance and repair by a patient, skilled and preferably independently wealthy owner. Difficulties with roofs, boilers, gas lines, trash chutes, elevators, plumbing are constant. Many times such equipment appears to work, but on close inspection, does not. Elevators may be locked or require a bellman, or have doors too heavy for a frail person to push. At one Loop hotel the desk clerk noted, "If I had a penny for every time I open those doors for old people, I'd be rich." Ways are found to overcome such impediments, but they are real impediments, nonetheless.

A typical lobby. It was recently redecorated.

The need for social contact, but also groceries and other necessities, are key reasons most older residents do leave the building regularly. Even the most disabled usually leave their rooms from time to time. Social contact is encouraged in hundreds of subtle ways by the hotel structure itself, with the decor and "attractiveness" of the lobby not necessarily being one of them. Most of the 27 hotels surveyed have a formal lobby or living room, but many show remarkably few signs of use. Those recently redecorated, having new furniture and carpets, frequently have notices from the managment nearby saying, "keep it clean," "Lobby for Guests Only," "Pick up your trash or we will have to close the lobby *again*. You know what happened last time." Even here hotel residents find ways to socialize.

The presence of a TV is a key indicator that the lobby is used and a clear message from the

management that socialization is welcome. But we also saw many desk clerk's with little TV sets watching day time soap operas. These also tend to draw an audience for specials, news coverage, and sports.

There is wide variation in the ways lobbies and frontage space is used. The cheapest hotels have all male residents and tend to be regimented, similar to a mission. One of these has about 30 chairs lined up in rows in front of the TV. The area clearly serves as a "living room" and the Tuesday we visited at two in the afternoon about ten men were watching a baseball game. Other places have threadbare but comfortable, overstuffed or barrel-type chairs against the walls or sometimes arranged in conversation groupings. The higher rent places tend to have new carpeting or furniture; a good entrance seems to be the most important renovation to give the whole building a new look. With this usually come signs about rules and admonitions about behavior. Most hotels have the lobby hours posted, usually closing at 9:0O or 10:00 pm. Some of the buildings also indicated they had "curfews."

As Jane Jacobs (1961) notes, the presence of activity invites observers, and observers invite other casual observers, which basically makes an environment safe and interesting. Thus even "dead" space is important, as are sidewalks and other features in front of the building. Many such open spaces, however, provide no place to sit down, and "hanging out" is certainly easier for people with mobility problems if they have a place to sit. The important thing for socialization, however, seems to be the availability of space itself. Few hotels appear to have gone to any trouble to create sociable space and some evidently try to discourage it. Masonry structures with little sharp rocks sticking up to prevent sitting, or little points on the top of lead pipe railings and fences suggest that a manager at some time has gone to great lengths to control the use of such public space. Fortunately, socialization "just happens" anyway.

Along with available social space is the attractiveness and utility of other commercial establishments adjacent to the hotel lobby or on the street: bars, cafes and diners, beauty shops, laundermats, grocery stores, delicatessens, drug stores, and barber shops. Occasionally such establishments are owned by the hotel management. Besides convenience, such features provide important stimuli to people who enjoy watching and being a part of the community, even when their mobility and resources are limited.

In the poorest neighborhoods these assets include soup kitchens, food banks and shelters where persons can sleep if they can't pay the rent through the whole month. One manager in Uptown observed, "Checks come on the first and third of the month, that's when people pay and

have money. By the end of the month several go on down the street to the Jesus People to eat."

A window with a view of the action means a lot to a person who does not get out much.

The placement of windows in the building is most important for residents choosing either to be in and a part of the action, or to be left alone. One 70 year old man who has lived in the same room with "my woman" for 20 years appears to be greatly attached to the window by his bed. He sat comfortably there, slumped over with a cigarette, looking across the street. We met him out front where he spends most days "hanging out watching the girls" at the junior college across the street, usually while drinking corn whiskey. His interest in women is clearly articulated, "even though I cain't do nothing about it no more," and confirmed by the collection of nude female photos across the wall on his side of the room. (His mild mannered "woman" has poor eyesight.) Asked if he would consider moving to a senior CHA building he declared, "No. They wouldn't let me do this--hang out and watch the girls and drink. No way, I ain't going to no senior building."

Another man told us he really doesn't like it down at his end of the hall, "too quiet down here, never any action." This man also seems unaware that he is very hard of hearing. However, the darkness and lack of a view may be part of his real frustration. A 68 year old retired waiter, whose floor is covered with vodka bottles, has befriended a whole flock of pigeons which roost on his small once elegant window ledge. He has named several of the pigeons, including one "who is 'Boss,'" enjoys them immensely, and occasionally allows the baby pigeon to strut around his room. Unfortunately, some residents with a nice window and a busy view have the shade drawn all the time. Since they are usually at somewhat of a premium, it seems a shame to waste a good window on someone who doesn't enjoy and use it!

Many hotels place most of their permanent and senior residents on the same floors and in some places seniors are being moved to the second floor apparently in compliance with city code enforcement and to facilitate exit from the building in case of fire. A secondary payoff might be the advantage Jane Jacobs describes, of having extra eyes and ears at the windows watching the neighborhood. Such surveillance makes the whole community a safer environment.

Besides the neighborhood itself, and how crime prone it might be, is the importance of safety measures within the building. At least some of this is reinforced by building features and procedures: bars on windows on lower floors, containment of traffic entering the front door which

is monitored by the desk clerk for strangers, use of the telephone to obtain permission for entrance of guests, provision of quality locks on room doors, hallways set up to allow visual surveilance of cul de sacs. Even heavy traffic by familiar people in hallways provides assurance that one's door won't be tampered with.

Residents vary greatly in the arrangements of their rooms and belongings. Hotels vary enormously in the furnishings they provide and there is wide room for creativity in the things people do with a room all their own over a long period of time. A TV is usually the focal point for those who spend much time in their rooms.

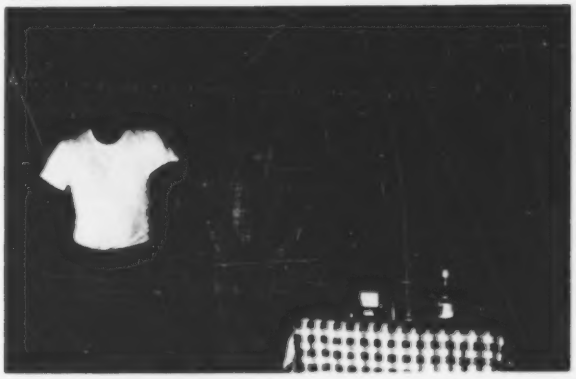
Bathrooms can be a special problem for the very old, but rarely seem to be. Three-fourths of the residents we interviewed have a toilet in the room or share one with the room next door. Most rooms have a sink. Bathing facilities are usually located down the hall, however, and subject to hard use by many people. Bathtubs are generally difficult to step into, very dirty, and difficult for old people to bend over to clean. Showers were much more popular, and fortunately more prevalent.

Eating well is an activity immobile people have substantial difficulty with, yet again hotel arrangements can informally facilitate this through socialization and access to commodities. Rarely can residents afford to eat at restaurants, so creative ways are found to obtain groceries, store food, and pool resources. About half the units we saw provide a stove and refrigerator (which are usually very old and have maintenance problems, but some buildings rent out newer small refrigerators. The rest have no refrigeration, necessitating storage of food on window ledges in winter and disposal of left-overs in summer.

Bathtubs can be especially difficult for the elderly to enter and clean. Cleanliness is not often found in communal bathrooms except at the best hotels.

Hot plates appear to be disallowed at hotels on the Near North Side and sometimes in Uptown, but not elsewhere. Where they are utilized the management provides heavy electrical cords, and great care and concern is expressed about them as fire hazards.

Both residents and management seem acutely aware of this, as well as the importance of being able to cook in one's room. Some very important social arrangements are sustained for years around grocery shopping and cooking. One of the nicest was a 62 year old amputee who regularly cooks in his room for an older man and a school teacher, and occasionally others. The teacher usually picks up the groceries and the two men pay the cook $1 per day. With this $14 he fixes breakfast and dinner for the three of them all week. When we met, he had just cleaned up from breakfast and was cooking chicken wings and soup for dinner.



Breakfast together at the Ritz. The man in the middle cooks for two other men twice a day on $14 a week. "We eat good."

Cooking and obtaining a decent diet is a substantial difficulty, however, for many. Many hotels are not located close enough to facilitate use of commodity programs, food banks, or senior meal sites or soup kitchens. Most residents, of necessity, plan their meals very carefully. Very few receive food stamps or any other government food commodities, although many have had them in the past. Many note that they cannot get to the office or stand in line for several hours anymore to apply.

A makeshift kitchen arrangement: electric skillet, hot plate, canned goods and work area. Note the walker has been recycled into a handy shelf.

The Inaccessibility of Formal Services

Use of formal social and health service agencies is relatively rare. Unusual is a 72 year old white man at a Near North hotel who receives meals on wheels and has two nurses visit daily from the VA Hospital. He is incontinent and non-ambulatory, but lives near the hospital. We met only one resident who utilized special transportation services which take him to appointments at Cook

County Hospital for one dollar per ride. (Even the severely disabled resident with degenerative arthritis usually pays full cost to take a taxi.) Despite the poor health conditions of most of these residents, little evidence is seen of other health care service. Most residents know very little of services that are currently available and lack the money to buy them anyway.

A few hotels, especially in Uptown, seem to have arrangements with social service agencies which provide mental health services to targeted clients who reside there. Some agencies, such as Travelers & Immigrants Aid and Thresholds, place large numbers of clients and actually do regular group treatment at hotels. This is the exception, but seems to work relatively well.

Unmet Needs

In summary, the major unmet needs that are prevalent among SRO residents reflect their limited incomes and lack of information. Key deficits include: medical care, psychiatric care, and nutritional assistance. We have not here detailed the health care needs of this population, but a cursory glance indicates they are staggering, starting with basic needs for podiatric care, eye glasses and vision care, hearing aids, and especially dental care. Very few residents have enough teeth to really chew. Along with their real fears of hospitals and medical treatment is fear of change of any kind, including routines, and fear of strangers.

While hotel managers all express varying levels of discomfort with "crazy" or unpredictable behavior and usually with people who use drugs, a few hotels have worked out satisfactory arrangements with agencies to be placements in exchange for the agency providing back up services. While most do not need the business this badly, more consultation and treatment would be helpful.

Summary

Hotel living is, by its nature, more likely to meet basic social needs than many other types of settings. Specialized assistance, though, especially medical and psychiatric care and basic durable medical equipment and supplies, cannot be provided easily and is badly needed by a substantial proportion of older SRO residents. Basic things like food, telephone, transportion are also needed, but most of these needs could be met by income supplemention and information.

Other services are identified by hotel owners and staff, but not necessarily by residents. These include actual service delivery, outreach, casefinding and case management. These services can be (and already are) delivered by neighbors and will be discussed in the last chapter.

CHAPTER 6. THE NEEDS OF OLDER CHICAGOANS AT RISK OF HOUSING LOSS: CONCLUSIONS AND RECOMMENDATIONS

Little could be more basic to human identity, the quality of human life, and the civility of society than that every person have a home with decent and private personal space in which to live, rest and be reconstituted. Such a basic provision is clearly not guaranteed to Americans. For the elderly the loss of a home and the security it provides is especially traumatic, and threats to such security are particularly worrisome. Losses leave scars not only on the immediate victims but also on communities. Thus, the especially human dimensions of housing and homelessness which we have highlighted here have special importance for *all* older people living in large cities like Chicago.

Homelessness among the elderly is a very dynamic state, typically short-term and not repeated, but not always so, and disturbingly prevalent among certain vulnerable older populations in certain neighborhoods, with certain endogenous and exogenous resources. Seeing homelessness and near-homelessness as a continuum of conditions rather than as a cateogry allows us to focus not only on its immediate causes, but on the range of precarious situations which potentially lead to loss of a home and/or to institutionalization. Examination of the experiences of Emergency Service clients and SRO residents has revealed some statistically significant differences between the resources of the elderly who have been homeless and those who have simply been poorly housed. These critical differences suggest unmet needs that concern us greatly.

Secondly, and related to this, the problems associated with homelessness and near-homelessness have some distinctive characteristics among the elderly which are not found among younger populations. Some of these might be considered causes of homelessness, but others are conditions that simply exacerbate persons' vulnerability to loss of residence and autonomy in the community. Finally, careful assessment of the circumstances, feelings and lifestyles of vulnerable older persons have very important implications for the provision of assistance to this population. Our analysis of them suggests important dimensions around which assistance must be organized and further research is needed.

Defining Homelessness

Our data has shown that homelessness among older people, while certainly not as prevalent as it is among younger people, has many of the same external causes: poverty, living in

vulnerable neighborhoods and buildings, and attenuation of social support. However, homelessness as a descriptor does not adequately capture the range of conditions by which the poor elderly, a group we would expect to be vulnerable, become devastatingly subminimally housed. Defining homelessness as part of a process or a continuum of conditions suggests the salience of a broader range of precarious situations. These are all relevant in a time of increasing shortages of low-income housing coupled with an aging society where "more and more of the elderly will be at risk for becoming homeless and will exert enormous pressure on government to provide long-term care." (Boone & Weaver, 1989) The governments of the United States face a looming triple-jeopardy in attempting to adequately rehouse the homeless in general, to care for a homeless population which is already "aging on the streets," and at the same time to plan for growing future long-term care needs.

Nor is homelessness a permanent condition. When viewed retrospectively and longitudinally, individual cases of homelessness among old people are remarkably diverse and complex. Simply finding an old person on the streets or in a shelter does not mean that such a person is homeless, even though official city agents and surveyors often presume this. Street surveys of the homeless have tended to obscure the array of at risk situations in which the elderly can be found, as well as to dismiss the significance of the elderly being homeless at all in a country which pretends to provide adequately for its senior citizens. The cases presented here illustrate the varied contexts surrounding homelessness. The clients' own explanations of these situations illuminate how they could or could not have been prevented or resolved. Each of the individuals we located had coped in different ways; some were able to avoid homelessness on their own, others became its victims with or without help, and a few made the seemingly unreasonable choice to become or remain "chronically undomiciled."

Vulnerabilities of the Elderly to Homelessness

Examination of these data and comparison with other studies of homeless people confirms that the sample studied here is very broadly representative of the needs of older low-income Chicagoans and that living on the streets is relatively rare among this population. As a group, those who have experienced homelessness show some significant differences from those who have never been homeless.

The classic homeless "type," identified by Rossi et al., Sosin et al., Cohen & Sokolovsky (1983) and Douglass and in earlier years by Bogue (1963), and Bahr and Caplow (1973) are largely "young-old" single men, frequently dependent upon alcohol, somewhat disabled, but

generally able to fend for themselves utilizing shelters and soup kitchens. Hoch notes that the increase in their visibility in Chicago is clearly related to the destruction of the West Loop and other skid row hotel areas and the continuing gentrification of certain neighborhoods. These men are most similar to the current residents we found in SROs, but while on the streets they get few benefits or services. They sometimes deliberately evade social agencies and medical care. Many have had lives of transiency. Alcohol appears to play a bigger role in their transiency and homelessness than it does among younger populations. With increasing age these men come to the attention of outreach agencies which still have a difficult time settling them down, except in nursing homes. Many more float around in the overnight shelter system or staying outdoors, collecting cans and scavenging, passively moving on, rarely relating with others, and quietly dying of traumas or untended diseases. These marginally functional persons, while less visible in the past, are more "exposed" now as the middle class has moved in on their neighborhoods and their previously cheap accomodations. They are usually seen as not appropriate for the mental health system. They are "aging on the streets" nonetheless, and highly vulnerable to the additional physical, mental and social deficits that come with age.

There appears to be an increasing proportion of women joining this group, partly because they tend to live longer and have even fewer economic resources than men. These women are more likely to move in and out of residential settings. Society is less accepting of a transient lifestyle for women and these women apparently are less adapted to it than men. Such women are more visible to social agencies and also more amenable to help. Other research confirms that these women are also more vulnerable to violence.

However, when we examine the entire elderly population who have ever been homeless in our sample, both Emergency Service clients and SRO residents, much of this characterization becomes stereotypic rather than accurate. Homelessness is *much* more characterized by short term episodes than by chronicity. Typically the most vulnerable to loss of their residence are those who live alone and whose locational or personal attachments are limited for a variety of reasons. They are especially subject to evictions for forgetting or refusing to pay rent due to dementia, the effects of alcohol, psychiatric problems, or declining health.

These briefly homeless individuals are much like those in deplorable housing conditions if they move into an abandoned building, a rented room in a strange neighborhood, or any further isolating situation. More typically, those living alone in deplorable conditions are there for a very long time. The common risk of those without housing and those in deplorable housing is the vulnerability created by poverty, as low monthly income is more likely to lead to inability to

pay rent at all and to eviction. Similar risks are created by poor health and isolation for the two groups, but longevity in a place makes a person dependent upon and attached to their environment, especially as they begin to experience a decline in health or cognitive functioning (Rubenstein, 1989). This kind of deterioration is less risky for older persons in SROs, congregate housing, or other more communal neighborhoods where informal care and assistance is likely to be available, or personal relationships have been of long duration.

Homelessness is not the ultimate measure of poor quality of life. On average even fewer of those in deplorable housing are receiving either informal or formal help, and they rate even lower on the total OARS scores than the homeless group. They were also less likely to be served more than once by ES or to be involved with other agencies of any kind. They typically lack the casual friends found in the SROs. Despite being somewhat more likely to have children or other relatives involved, their situations are extremely difficult to deal with. Guardianship is frequently recommended but difficult to establish, especially for persons without relatives. Evidence suggests that agency inability or unwillingness to respond to the deterioration of such persons can have disastrous consequences. When forced to relocate by either social agencies, an eviction, or inability to pay rent, taxes or the mortgage on a house, the largest proportion of such clients go to nursing homes or places unknown. Of those who go to nursing homes, most do not live long.

Individuals who endure extreme losses or hardships in their elder years, sometimes prolonging life long patterns, sometimes seeking and sometimes evading the attention of the service networks, appear resigned to tragic consequences. Although it appears that many slip through the cracks in our service systems, their disappearance is not necessarily the fault of formal service providers. A number of underlying factors help explain how such seniors end up in precarious situations and why, in many cases, services are not received until the situation reaches crisis proportions or, in some cases, never reach them at all.

The inevitable result of such a trajectory is tragic, wasteful, and costly for society. For such persons, shelter is used to a surprising degree, usually as one of the most expedient resources available. Yet, shelter placement for a person overly attached to familiar surroundings is frighteningly disruptive. A colossal effort is required for return to normalcy, either at home or elsewhere. Effective but always tenuous relocations are made to public housing and in informal care through agencies, but regular monitoring is usually necessary to assure their stability. Any permanent settlement is almost inevitably made by a hospital, to another

health care institution, involves public expense through Medicaid, and usually occurs when the client already has no other options or does not have long to live.

Some clients who remain in deplorable housing conditions without consistent assistance die through trauma and accidents, acute and preventable illnesses, or through inevitable deterioration due to chronic conditions. Deterioration is expedited by the neglect.

Precipitating Factors in Homelessness Among the Elderly.

In the face of a forced relocation, the elderly must cope with the added hardship of declining health and functional capacity, fewer social supports, and sometimes diminishing economic and mental capacity. The combination of multiple resource deficits is clearly the most potent predictor of losing one's home. Loss of mental capacity is the most salient as a complicating factor in inability to maintain surroundings, but loss of income, loss of financially supportive persons who share household expenses, and evictions remain the clear precipitants of homelessness. Without these predisposing factors and trigger events, the senior can frequently remain in deplorable, subminimal housing in a condition sometimes even more indecent than that of the homeless. The significance of these factors as precipitants will be discussed separately in terms of those interviewed.

Aloneness and Lack of Social Support

A lack of social resources most clearly distinguishes the homeless from those who have never been homeless, but resources can be available in a variety of ways. Even when personal support systems have attenuated, informal systems may be strong or have such a history as to continue to be helpful. Aloneness appears to be less of a factor for the elderly than it is with younger homeless populations. Many elders do live alone but have well developed coping capacities or receive substantial informal help. Indeed, life long aloneness (having never married or had children) may have actually produced more adaptability or resourcefulness. However, the *loss* of social support one depends upon, compounded with reclusive isolation, personal neglect, and/or depression or other mental problems is very serious, as is loss of any of the other resources for those whose reserve of social resources is already low. Such isolation is a critical factor in the situation of those in deplorable housing conditions.

Diminished Mental Functioning

Among elderly ES clients, diminished mental functioning resulting from loss of cognitive capacity, psychiatric disorders, and chronic alcohol abuse is the most prevalent corollary with need for service, affecting 20 to 30% of our large ES sample (n=479), especially the very old.

This suggests that a substantial portion of the city's elderly are at risk and that, in the absence of other programs, city agencies (police, fire, and human services as well as aging programs) bear a large responsibility for their management. Fully half of the interviewees who were ever homeless and one-fourth of those in deplorable housing conditions present evidence of psychiatric or cognitive impairment. There is no question that cognitive deficits play a major role in situations that lead to homelessness among the elderly. Such homelessness is inherently different than that of younger populations.

Dementia is one condition with which society is normally sympathetic and provides attention through the service system, but if the client is also resistant, violent, or even simply passive, agencies which intervene often accomplish little. Behaviors that are a product of dementia--wandering, getting lost, and being unable to manage personal space and business--are a common reason seniors get referred to ES and other agencies.

Dementia is often confused with and compounded by psychiatric problems. Differential diagnosis between dementia, psychosis, and depression in the elderly is difficult for even trained specialists, so that we expected dementia to be noticed the most. Indeed, dementia is common in our large ES sample. Psychosis was less frequently mentioned in the ES records and in information obtained from others than was dementia. In contrast, however, among the housing risk sample (those homeless and in deplorable conditions), there was a substantial amount of psychiatric impairment mentioned while the most psychosis was seen among those who had ever been homeless, including the self-evicted and paranoid who took themselves to the police. This was significantly more than among any other group ($p=.009$). Despite this, the elderly in need of temporary shelter are much more likely to become institutionalized in nursing homes than in mental hospitals. Apparently the elderly are usually perceived as unable to benefit from psychiatric treatment and so are rarely admitted.

Very Low Income

A key distinction between the ever and never homeless is a relatively small amount of monthly income. On average the difference is only $595 and $434, and the income for the currently homeless on whom we have information is much lower than this. With SRO rents averaging $250 it is easy to see why the margin for those who become homeless is simply too slim to secure or retain stable housing. This destitution is related to the fact that a substantial proportion of those interviewed have not applied for or are not receiving all the income and in-kind benefits to which they are theoretically entitled. This is due to lack of access and information: lack of transportion, telephone, and television; inability to read, fill out forms,

follow directions and gather documentation; inability to tolerate stress, lengthy bureaucratic processing, and patronizing; and inability to stand for long hours in line.

Conclusions and Recommendations

Providing Consistent and Critical Assistance

How can services be provided with a declining amount of low-income housing and a growing number of elderly people and housing related problems, including homelessness, among them? In many ways it seems that service systems are being asked to do the impossible.

How can assistance be provided to housing risk clients that truly meets their needs? Effective services must provide extra help and minimize risk, maintaining the equilibrium of current support systems (albeit fragile ones) while still retaining client autonomy. The key provisions must be preventive and early enough to deter both the loss of housing and premature institutionalization. The purpose of any such interventions should be fundamentally to *listen* carefully to the stated and implied needs presented by the senior clients so as to respond to the needs they recognize. By addressing their perceptions of what they need, and providing essentially *what they want*, the basis of a helping relationship is established.

One major route through which this could be provided to high risk elderly persons would be through provision of vital concrete services that people want and need where they live. The receipt of such service subtly obligates the client to relate and respond to the provider. Ideal for such purposes are basic health care services and health monitoring which this population, given their lack of resources and fear of hospitals and medical personnel, desperately lacks. Provision of basic care such as toenail clipping, denture repair and prophylactic gum care, eye exams and provision of glasses, nutrition monitoring and provision of fresh and balanced food or meals, medication monitoring and regular refilling of prescriptions could not only establish rapport and trust with the provider, but allow the opportunity for passive health monitoring. Regular contact by health care specialists at the same time could follow and treat conditions such as hypertension, diabetes, cancer, alcoholism, metabolic disturbances, and heart conditions, the results of which are devastating.

Such care, however, is not unsophisticated, and psychiatric consultation needs to be part of it. An example is the Psychogeriatric Assessment and Treatment in City Housing (P.A.T.C.H.) program of Johns Hopkins University operating in half of the senior housing complexes of the Baltimore Housing Authority (Tlasek, et al., 1989). Approximately 13% of these residents are

estimated to suffer cognitive impairment, and the program treats approximately 10% of the residents at each building. Responding to housing staff referrals, as well as self-referrals, the program provides consultation, casefinding, and treatment to chronically mentally ill residents suffering dementia, depression, and schizophrenia. By providing consistent direct treatment, it has deterred both evictions and unnecessary institutionalization. Providing direct benefits is a vital basis for beginning to win the trust of such clients.

In addition to health care, home repair and chore work to repair and maintain the living quarters of frail elderly persons is similarly needed, whether elders' homes are owner occupied or rented. Situations ranging from the repairs of the New Jackson Hotel to restoration of Josie Hicks' home to the maintenance of Viola Cooper's apartment all require public subsidy of some sort to deter further deterioration and to guarantee access by poor people. Repair and chore services can assure that utilities are working, that broken windows are replaced, that vermin and burglars cannot get in. Unfortunately, it appears that because "systems" of service now are afraid of benefiting some gouging landlord, we are more inclined to move old people from uninhabitable homes rather than make them into decent housing. Financing might be possible by placing a lien on the property or collecting the rents until the cost has been repaid. Correction of imminent danger and repair and reconnect of utilities and necessities is action which can effectively engender appreciation and cooperation from even the most resolute recluse, forming the basis of a helping relationship of strategic importance as the client continues to reside in this dwelling.

A second route through which important services could be provided would take lessons from daily life in SROs and neighborhoods with a strong sense of community. We know that autonomy can be facilitated with minimal assistance, and that sometimes quite complicated assistance is very effectively orchestrated through natural helping networks. We are reminded of a man we located in a South Side rooming house who had taken care of the old and dying alcoholic man in the room next door. The Department on Aging and Disability had sent out a homemaker, but she was allegedly attacked in the neighborhood and refused to go back. He said, "I carried him, I cut his hair, I cooked for him--and I got him looking pretty good, too. And I took him back and forth to the hospital. . . and nobody ever paid me nothing."

This most basic kind of assistance, besides basic hands on care, is simple daily contact, surveillance and monitoring, attendance to needs, and accessing of resources. The key to such effective help is the existence of meaningful relationships and some sense of satisfaction for the caregiver. We can think of no more effective caregivers than the ones clients might choose for

themselves, ones who are close by, easy to talk with, willing to help, matter of fact and likely to be already providing help. But such neighbors, relatives, friends and hotel staff have no obligation to help. If we want to sustain and promote this kind of assistance, as a society we need to provide incentives and reinforcement for doing so, providing a return that is meaningful to the caregiver, even when the client can no longer express gratitude. Reinforcement could take the form of rewards, recognition or financial compensation, but clients and caregivers should have choices in selecting these "reinforcers."

It seems reasonable to reward the informal caregiver for making a commitment to providing care for a set period of time. Given that hotel residents and staff are generally living below the poverty line, as are relatives and neighbors in poor neighborhoods, meaningful compensation levels need not be high in order to offer distinct incentives for the provision of such care. Such helpers can be of further value to agencies in doing case finding and outreach. Models for compensation programs are the Michigan Adult Home Help program (Keigher, et al. 1989) and the VA Aid and Attendants Allowance Program (Adamek, 1989). Each allow the client to select a caregiver of his or her choice who is paid a cash stipend based on a functional assessment of the clients' need. The maximum payment in the Michigan program is $333 per month.

In this same vein, funding for low-cost housing is imperative and none of these recommendations will be meaningful without it. Public support is necessary given the financial situation of those who have experienced homelessness, evictions, and most poor housing conditions. New units are needed, and some of such developments must provide supported care. Housing developments should recognize the importance of supportive housing and small group homes, places where natural helping relationships can develop and services can be provided with convenience, efficiency and non-intrusiveness. Some of such developments should be purposefully intergenerational. We must recognize that nursing homes are neither necessary, cost effective, nor humane for most low-income elderly persons (Kane and Kane, 1987) and certainly for most of the elderly we have described here as well. However, permanent low-income housing, supported and facilitative of access to services, offers a reasonable alternative in which the frail elderly can live out their days.

Finally, in the absence of indigenous helpers, formal agencies that provide home care services must be aware of the sensitivities, attitudes and prejudices of high need clients, and understand how significantly feelings and preferences affect clients' ability to accept services. There is need for appropriate assessment and flexibility in assigning helpers that are acceptable

to the client and for recognition of fears, and respect for privacy. It may be better to send no one rather than a helper who will discourage the client from seeking further help. The "service" that the agency has available is not necessarily what the client needs or wants!

This is as relevant in interventions with crises as with any other need. There is a grave need to link up emergency services with followup services of other agencies that will continue to provide ongoing care. Too often emergency intervention provides a cataclysmic disruption but ameliorates very few basic needs. The magnitude of the immediate problem and need to respond quickly leads inevitably to a bureaucratic response: choice from a short list of short term options. The overwhelming problems presented by the housing risk clients we have identified make typical crisis responses quite inappropriate. Indeed, the basic problems are not emergencies at all, but chronic conditions of grossly inadequate resources (Lipsky & Smith, 1989). Besides provision of decent housing, food and medical care, ongoing casework and continuity in attention are fundamental.

Needs for Further Research

The findings reported above suggest two further areas of study that would improve our understanding of the housing risks of the elderly, as well as the capacity of our social service systems to respond to them. The first involves developing a more fine grained understanding of the behavior and needs of the kinds of elderly housing risk clients that we identified in the present study. Three categories of issues deserve further analysis. All have immediate relevance for improved design of social services. They include the following:

What is homelessness and housing risk *from the point of view of the elderly* person experiencing it? Such research would explore what constitutes "home" versus having a place to stay, as well as the meanings housing experiences have for the elderly. To further understand the perspectives of the elderly on homelessness (and whether this state is a valid or distinct category for them) we need to draw attention to what constitutes the range of alternatives in a continuum of the housed and the homeless (e.g., institutionalization, hospitalization, "subminimal" housing) and what these conditions do to the individuals experiencing them. An inherent issue within this framework is that of attachments--to places, people, memories, things, etc. An example of such analysis is Rubinstein's recent article (1989) on the meaning of home for the elderly.

What kinds of emergency shelter and other services are used by older adults and what does this mean to them? This issue not only suggests focusing on what *is used* but also when and

under what conditions are shelters and other services *not used*. What are the kinds of nonuse and what explanations do the elderly give for refusing services?

A third category of analysis revolves around the interrelated issues of coping capacities, survival strategies and autonomy. In order to better serve the elderly at housing risk (both those needing relocation and those needing other services), we need to understand how some elderly people cope in the face of grave housing difficulties--how some survive and even maintain a degree of autonomy while being homeless, while others do not. Issues which are deeply interconnected include:

- elders' explanations of how they survive (whether homeless or at risk) and their descriptions of the loose collection of informal and/or formal resources they turn to,
- their perceptions of their life and lifestyle focusing on issues of fantasy, denial, privacy, independence and fear,
- internal intervening factors which appear to play a part in their housing risks and/or their ability to accept services, such as alcoholism, dementia, mental illness, fearfulness, reclusiveness, and dependency conflicts,
- external intervening factors which impact upon housing risk and service use, including abuse, neglect or estrangement by others, deteriorating health, loss (financial, social or otherwise), support of dependents, etc.

A holistic, in-context examination of the situations of elderly individuals along these suggested dimensions may reveal elderly types or categories of at risk individuals prone to slip into homelessness or other equally unhealthy conditions. This would allow a more careful and judicious targeting of preventive and interventive efforts by emergency as well as case management services.

The second area of research that is needed would draw upon the first, but would focus on agencies and how *they* are coping, given the apparent unresolvability of problems presented by many high need clients. For example, starting with the randomly selected sample of housing risk clients in this study, systematic research would examine these clients' sources of *formal* help and the utility of such help from the clients' as well as agencies' point of view. By looking "from the bottom up" at the system of services, research would identify agencies in the emergency service network as well as the aging network and examine how each typically responds to elders in crisis. It would examine both stated procedures and policies, as well as actual practices. Agency "responsiveness" would be explored regarding how elderly persons get into the emergency service system and beyond. The study would acknowledge agencies' perceptions of

elderly clients and their definitions of need, and begin to identify what flexibility agencies have in what could be more creative packaging of services. An analysis of this sort would build upon Lipsky and Smith's recent article (1989) on the costs of treating basic social problems as emergencies.

In conclusion, we must state unequivicolly our conviction that all the diagnostic resources, client service, and research in the world is not going to alleviate the "growing crisis in urban housing" which is threatening a substantial portion of our elders, as well as families and children and working people in the prime of their lives. According to the National Housing Task Force (1988), from 1974 to 1987 the number of households with incomes under $5,000 (in 1986 dollars) grew from 2.7 million to 4.7 million. Yet, in that same period our nation's production of federally subsidized HUD housing has dropped on average from 167,000 units per year to less than 25,000, an 80% drop in the past decade. This erosion is compounded by the potential loss of more than one million more units of federally assisted housing through the termination of low-income restrictions or the expiration of subsidy contracts. And current production efforts offer little hope of providing more low-income units in the near future. A sizable and growing proportion of our population is underhoused, unhoused, or living in uninhabitable conditions.

Until our nation adopts a federal commitment to a "housing for all" policy, development patterns of American cities are going to continue to force those with limited resources and marginal housing into homelessness. The cost to all agencies of "servicing" such persons--of outreaching, case managing, arresting, "guarding," following up, crisis intervening, band aiding and intensive caring--appears to be far greater than that of simply housing them decently in the first place (Lipsky and Smith). The many services we have described here, that have been demonstrated and proven effective over and over, do not work in the absence of a decent and affordable home.

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APPENDIX A

METHODOLOGICAL NOTES

This study has attempted to blend both quantative and qualitative methods in its approach, utilizing a data source that was believed to provide a unique but comprehensive view of the varied needs of Chicago's seniors. In contrast to "street survey" methods of identifying the homeless, it relies on client records to provide clues as to their homelessness. While it certainly incorporates homeless people, it does not do so in great numbers.

Possible Methods

Sosin and associates note (p. 21) that much of the confusion over counting the homeless has arisin because of differing approaches to "counting them derieved from different definitions of what homelessness is. He sampled only from preselected census tracts and only those persons literally on the streets, in abandoned buildings, and in public from 1:00 a.m. to 6:00 a.m. with no place to go. The study also coutned persons in shelters. (For an annotated bibliography of homeless studies including comments on methodology refer to Douglass (1988).)

Sosin and associates' study, however, used a wider sampling frame to survey persons who were likely to be living "doubled up," in treatment programs, or otherwise not paying rent. His researchers interviewed people at the places where they were most likely to go for necessities or to obtain services, such as food pantries and shelters. He mentions a third type of homeless person which his survey could not include, short term homeless persons and families housed by agencies in motels or with a vendored provider, who are scattered across the city. He estimates that this group would be relatively small on any given night. Because they are served by a variety of public and private agencies, he notes that this group's experience has important implications for policy making.

The present study has a special interest in this third type of population, especially in terms of what the public sector does for this group. The sampling frame in this study includes agency data/case records on clients who have been vendored, as well as the bulk who have received no such assistance nor need for shelter. The approach used here has an additional advantage in that it incorporates interview data as well as case records. The Kutza (1987) study cited above is an example of a case record review, but in included no interviews. The present

study does both, and supplements this with further information gathered from other agencies, as well as friends, relatives, and neighbors familiar with the client.

Data Collection

Research Schedule

Research was conducted from June 20, 1988 through Feb. 15, 1989. A pilot study of City records of emergency services to the elderly was conducted in the summer of 1987. The research schedule is outlined in detail below.

Summer of 1987	ES sample of 125 drawn
June 20 to August 10, 1988	Additional sample drawn and descriptive data from agency records collected.
June-July, Sept-Oct, 1988	Survey of SRO hotels .
June to July, 1988	Interview instrument developed and tested.
Aug 1 to Dec 18, 1988	SRO resident interviews conducted.
Aug 1 to Dec 18, 1988	ES interviews conducted.
Nov 1 to Feb 15, 1988	Analysis and write up.

More time than originally intended was spent in negotiations with city officials to secure access to their files, in developing and testing the assessment instrument and in locating elderly ES clients. These delays pushed back data analysis by two months. The follwup contacts originally planned were made impossible by these delays. However, because research staff were still available to receive calls from agencies, friends, relatives and neighbors throughout the fall, much followup information was gathered in this way. In some instances more than one visit was made with the client.

Samples

The ES Sample

After initial screening in the telecommunication center to determine if an emergency actually exists, ES teams are dispatched by car to respond to calls for help. These teams complete a contact card for each situation on which they are dispatched. These cards form the ES files. The files consist of 55 drawers, each containing an average of 864 cases. Approximately

11% of these are blue cards which designate clients aged 60 or older. Therefore, sampling consisted of picking four-digit random numbers, the first two digits designating the drawer and the last three digits designating the number of the blue card within the drawer. If the drawer did not have as many cards as the number drawn, that number was discareded. In this way, each card had an equal chance of being drawn.

However, since the ES team is charged with dealing with the immediate emergency and referring the individual elsewhere for any further help needed, the data gathered at an intitial contact is minimal, serving only to deal with the problem of the moment. Names, ages, sex or race are not always recorded. More explicit identifying information (i.e., social security numbers, last known address, names of family members) is less likey to be recorded. As a result, the files contain records with the same name, but often nothing to indicate whether or not these are hte same individuals. The sample is therefore not ideal, but within the limitations placed by an operating program that is concerned only with single interventions at a time of crisis, the sampling process has not added to any biases that may already exist in the agency records and there is no reason to suspect that systematic biases exist that would invalidate our conclusions.

From a universe larger than 47,500 client contact records from 1984 to1988, two samples were utilized. The first, drawn in the summer of 1987, consisted of 125 cases of clients over the age of 60 where the last recorded emergency occurred any time before July 1987.

In June of 1988, a second sample of 479 senior cases was randomly drawn from all ES records (approximately 9.2% of the estimated 5200 elders in the file at that time). From this set of 479 cases, four types of clients were identified: individuals who had no record of housing related crises; those who had a record of having been in need of temporary housing or shelter or had been evicted; those whose record indicated substandard housing conditions; and those where there was recorded both poor housing conditions and the need for temporary shelter. Cases where fire had been recorded, but no effort had been made to arrange shelter, were included in the first type. The second, third, and fourth types were considered "housing related crisis cases."

Comparisons made between these four types are generalizable to the full aged client population of the ES program.

A sub sample of 115 cases (including 123 clients--6 couples and 2 sets of sisters), was

identified and selected for interview. This was a purposive sample, chosen as having had housing related crises and recent enough contact withthe agency so that there was good liklihood of being able to locte and contact them. These 115 cases included both housing conditions and shelter need clients. Fifty five came from the new (1988) random sample of 479, specifically from the subset whose last contact with ES had occurred in the past year and would be easier to locate. Sixty came from the original pilot sample drawn in 1987 (Keigher 1987) whose last contact was anywhere from 1 to 3 years ago and thus were more difficult to locate. This sample was representative of the ES cases which were housing emergency cases.

This sample was designed to permit the comparison of characteristics of older persons in a variety of risky housing situations: the undomiciled; those in their own homes; and those in a variety of other types of housing.

However, of these 115, it was actually possible to locate and obtain in-depth information on only 91 cases. Therefore, the interviewed sample is no longer a random sample from the files of housing crisis cases.

The SRO sample

SROs were drawn from a sample used in a previous University of Illinois study of Chicago SRO houisng conducted three years ago. This city wide weighted sample of 18 hotels were of varying sizes when interviews were conducted previously. This was ideal for replication because of its representativeness. Investigators from our study contacted all 18 of these same hotels, but could only get complete assessments on 12 of these. Fifteen more hotels in areas where neighborhoods (including SRO's) appeared to be on the verge of gentrification and redevelopment or were already undergoing transition. This added to our sample 6 other hotels in Uptown, 1 in the West Stadium area and 7 in the South Loop. The total sample of 27 represented the following six priority geographic areas: 1)Uptown-Edgewater- Lakeview, 2) North Loop, 3) South Loop, 4)West Side near the proposed Bears Stadium, 5) Westown-Humboldt Park-Logan Square, and 6) Grand Boulevard-Kenwood-Oakland.

In addition to the characteristics of the hotels, the characteristics and preferences of the older residents were studied. A sample of 30 residents aged 50 and over living in 12 selected SROs were identified and interviewed to obtain equivalent demographic data for comparison purposes. A sample both older and younger than age 65 where chosen in order to compare the importance of social security and other entitlements in personal choices. With an estimate of the

number of seniors in each hotel, interviewees were chosen on site at each hotel by selecting every 11th room from a list of all residents over age 50 in the hotel developed by the hotel manager or desk clerk. Where a couple lived in the room, they were usually interviewed together.

In fact, however, the choice of those to be interviewed was partially determined on the basis of who was available and willing. Consequently, those elderly who worked or were otherwise busy during the day were les likely to be interviewed. When an elderly individual was not available for an interview, either because they refused or were out or were at work, another individual was randomly chosen from the list. In one rare instance, only one person at a specific hotel was available. In addition, the list developed was limited by the knowledge of the management, who were sometimes uncertain of residents' ages.

The net result, however is that this sample cannot be considered a valid representation of older SRO residents. This approach biased the survey against finding certain types of older persons in SROs, espeically those who were employed. It may also fail to pick up identifiable chronic homelss persons. On the other hand, among both the ES and SRO samples are seniors who have experienced homelessness and who have not.

A brief questionnaire was also administered to about 40 other older residents of these same hotels.

Interviewers

A total of 5 interviewers were employed (all female, four white and one black), 3 of whom were with the project throughout most of the interviewing phase. Their academic backgrounds included social work, sociology, and anthropology. Two of the five had doctoral degrees, two had masters degrees, and all had previous interviewing experience. Interviewers were trained in the field by the principal investigator. Interviewers worked in teams of two for several reasons. First, it was possible to collect more complete data on the elderly individuals current situation with one interviewer free to observe and take notes on the living conditions and the respondent's reactions to questions. Secondly, it was often necessary to search for respondents, whose last contact with ES was sometimes up to 3 years ago, with rare assurances that they would still be at their last known address. Due to the nature of the neighborhoods in which respondents had lived and our lack of knowledge of the buildings being approached, teams were more appropriate for the safety of the interviewers.

Sources of Data

Agency Records

In addition to the coded information from ES records as described previously, additional descriptive client data was gathered from the client files of the DHS Youth and Family Services follow up senior unit, DAD case Management Units, and Travelers and Immmigrants Aid Health Care for the Homeless (HCH) on each case where it was available. Agency records were recorded verbatim and all referrals were noted. The kind of information collected from ES records is described in Chapter 1. Additional information was gathered from conversations with agency personnel while trying to locate the interview sample.

SRO Interviews and Observations

A total of 33 hotel assessments were completed (See Chapters 4 and 5), allowing a broad view of the attributes and deficiencies provided by hotel living to older residents. (A copy of the assessment instrument is available upon request.) Additional information (a short questionnaire asking residents to list their age and what they liked about living in this hotel) was gathered from about 40 older residents of these same hotels.

An ethnographic approach was used with interviews of hotel managers, owners, and desk clerks. At least an hour was spent (sometimes more than once) with these individuals discussing the characteristics of the hotel, it's suitability for older residents, listing the hotel's elderly residents and describing the management's experience with them. Many other informal discussions were held in hotel lobbies, residents' rooms, and hallways with groups of residents, desk clerks, maids, bellmen and janitors.

Interviews and Observations of the Elderly

An indepth "extended client assessment" interview instrument was developed and pilot tested in June and July. This instrument combined the Duke University Older Americans Resources and Services (OARS) instrument, questions used in a recent study of homelessness in Chicago (Sosin 1988) and the recent Ethnic Elderly Needs Assessment done for Chicago Department on Aging and Disability. This instrument was designed to measure the individual's health and mental health status, their functional ability (ADL), social and familial support, and their housing history, condition and prospects. Data on housing also provided a longitudinal

in-depth retrospective view of clients' residential history and gave a *feel* for what would happen to older adults who might have to move. The interview instrument was designed to be administered in 30-40 minutes and to stimulate narrative responses. Interviews actually lasted between 30 minutes to 1.5 hours. The same instrument was used for interviews with both SRO residents and ES clients. About two-thirds of the interviews were tape recorded and the rest were not because of either refusals or technical problems. All those interviewed, in addition to other informants who provided us with extensive information, were paid $5 for their time.

Of the total sub-sample of 115 cases (123 clients) chosen for interview and further data collection, in-person interviews were conducted with 50 clients, including formal assessments with 37. (Formal assessments could not be completed on 13 where the client was too cognitively impaired, ill, weak or unwilling.) Ancillary informants provided a formal assessment on another 6 cases for a total of 43 formal assessments. In addition, ancillary informants provided useful data on 86 cases. In sum, in addition to formally conducted interviews, a wealth of information on housing histories, lifestyles and the health, mental health, economic and social situations of these individuals was elicited in less formal dialogue from elderly clients, family, friends, neighbors and agency sources. A fairly to very complete case history was compiled based on combined sources of information on 91 of the 115 cases in the interview sample, resulting in an overall 79% response rate.

Interviews were conducted with the 30 SRO residents as mentioned previously. Hotel managers, owners, desk clerks, maids, bellmen and janitors were also interviewed concerning specific elderly residents and the management's experience with them .

In all interview settings, observations made by the interviewers themselves were recorded as a separate source of information. In many cases we also collected sketches or photographs of the elderly invidual's residence.

Locating the ES Clients and Variation in the Quality and Quantity of Data

Unlike street surveys or other on site random samples of the homeless, the portion of this study concerning the 115 ES clients began with a list of names of those who had received services from ES from 1 month to 4 years *in the past*. The retrospective nature of these events presented significant problems for gathering data, but also offered some uniquely valuable information. Given the amount of time that had lapsed since service, the often transient housing pattern of many individuals and the lack of formal agency information regarding most of the "in

need of shelter" clients, locating past clients of ES presented a challenge. An average of roughly 11 hours per case was spent: contacting agencies, including shelters, hospitals, the police, clients, relatives or neighbors by phone and in person. A substantial amount of this time was spent talking with relatives or persons in the neighborhood of the client's "last known address"and visiting numerous shelters and drop-in centers in efforts to locate individuals. As a result, the quality and quantity of data available on the 115 clients chosen varies, as noted previously and below.

Persistant searching for these individuals was productive in most cases and the information on these individuals is now as complete as any collected on similar homeless populations, and in many cases much more indepth. Because of the time elapsed since ES contacts, the study provides a uniquely longitudinal, retrospective view of their housing patterns and experiences. The clients' own explanations and interpretations of events, fit into a larger pattern of events, now yield particularly rich qualitative analyses.

Despite the variation in the quality and quantity of data, overall it allows for richer and thicker description than anticipated. Because of the extended time spent in locating individuals we were able to contact more informants than previously anticipated and therefore collect multiple accounts of the individuals situation in many cases. However, this was not possible in every case and this variation along the lines of number or sources as well as the extent of and reliability of information must be noted.

For example, in a few cases we were unable to contact anyone beyond already existing agency records. In other cases we were able only to contact a friend or neighbor. Yet in a considerable number of cases we were able to collect information from the elderly client, several other informants and sometimes several agencies. In some instances, informants were particularly knowledgable while in others very little was known about the client. This approach proved particularly valuable in accounting for clients who were no longer interviewable, either deceased, institutionalized or otherwise incapacitated.

Secondly, data collected from the respondents themselves, even when interviewed, was sometimes affected by a number of limitations. In some cases the subject's state of mind (e.g., due to alcohol consumption, mental illness or dementia) did not allow for "accurate" accounts of the individual's situation. In the cases where we only have the account of the elderly individual (as is the case with many SRO residents) there was no way to compare multiple accounts for discrepancies and informative incongruities. Additionally, the relationship of the interviewers

to the informants sometimes involved a certain amount of fear, distrust or anger (at being disturbed or at being "studied") which affected the amount and kind of information collected. Due to fear, distrust and habitual "conning", some informants were evasive; information given sometimes drastically contradicted other informants' accounts. This is not to suggest that some accounts of an individual's situation (even by elderly respondents) are wrong. The incongruities between accounts offer much information in and of themselves about values and coping mechanisms. Howver, the fact remains that we were unable to collect multiple accounts in all cases, due to the limitations suggested above. What we do have, however, yields valuable information and insights.

As a result of incongruities in the data, it is necessary to make some assessment of the reliability of the information that we have. The interviewer made this assessment on the general reliabltiy of the information gathered by interviewing the individual himself. For specific data, when it was not clear which verson of a fact was accurate, or when information was not given, but the interviewer had s strong hunch about it, this information was entered as questionable or unconfirmed. Unconfirmed or questionable data are not included in any analyses unless they are so labled. Thus, if it is not clear whether the individula lived alone or with someone else, this variable was coded as unknown. However, if it was extremely likely that an individual had at some time been homeless, but we had no direct confirmation of this, it was coded as "suspected, but unconfirmed." Any analysis comparing those who have been homeles with those who have not was done omitting the individuals for whom the data were unconfirmed.

There was no reliability rating (of the information provided by elderly respondents) for 60 of the cases where the elderly individual was contacted. For the 58 with a rating, 17 (29%) were coded unreliable; 22 (38%) were coded reliable; seven were coded as not applicable (no client interview); and in 12 (21%) the interview was unable to determine whether the information was reliable.

Data Management and Analysis

Data was collected from a variety of sources, as has been mentioned previously. All information on interview sample respondents was kept in individual file folders and both files and tapes were given code numbers for purposes of confidentiality. Information from different sources (including agency records, phone calls and face to face conversations and interviews)

was labelled as to source, date and context. The researchers on observations were also recorded and labelled as a separate source of information.

Of the larger sample of ES clients, the total 604 ES cases were coded on the basis of previous coding in the 1987 pilot study--for demographic data, the number of people in the client's household, the referral source, ES contact dates, the nature of the crises (presenting problems and other problems), living arrangements, services received and referrals made. Further coding was done on data collected from the interview samples--both for ES clients and SRO residents.

Several methods of data analysis were utilized to assist in coding and interpreting the data. During the course of data collection, a student working with DAD constructed helpful timelines of agency interaction (ES, YFS and DAD) with ES clients who had also been served by DAD either before or after ES contact. Detailed review of inteviews and ancillary information on respondents from the interview sample was used to construct housing history timelines. These housing histories included and summarized information on relocations, reasons for relocations, household composition at each move, any significant losses (e.g., social or economic) and mention of discrepant accounts from multiple informants. In dealing with contradictory housing history accounts in the case of one client, the most plausible housing history was recorded based on agreement between informants through triangulation of data sources. However, strong discrepancies and denial were also indicated in the housing history summaries.

APPENDIX B

TABLES

Table A1 Comparison of Random Sample to Chicago Elderly

Characteristic	Population age 60+ Chicago	Sample
proportion female	59.3%	59%
proportion white	71.7%	45%
proportion age 75 and older	26.7%	44%

Table A2 Problem Incidence for All Cases

Problem	n of cases	% of cases
Lost, confused, wanderer	123	20.5
Fire	111	18.5
Transportation	111	18.5
Temporary housing	100	16.7
Medical care, treatment	76	12.7
Health	61	10.2
Needs Food	48	8.0
Psychological	46	7.7
Poor housing conditions	45	7.5
Assessment of needs	37	6.2
Uncooperative	34	5.7
Victimization	33	5.5
Eviction	29	4.8
Chronic homeless	25	4.2
No utilities	23	3.8
Drunk, alcoholic	21	3.5
Needs other living arrangement	19	3.2
Handicapped	15	2.5
Dirty, smelly	10	1.7
Belligerent	5	0.8
Feeble	4	0.7
Unable to care for self	3	0.5

Table A3 Frequency at which problems are noted together

Instances	Problem 1	Problem 2
11	Temporary shelter	Transportation
5		Wandering/lost
4		Eviction
3		Needs food
2		Medical eval/care
1		Fire
1		Victimization
1		Other living arr.
4		Other
11	Transportation	Temporary shelter
3		Needs food
2		Wandering
2		Medical eval/care
1		Eviction
1		No utilities
1		Other living arr.
5	Wandering	Temporary shelter
2		Transportation
1		Needs food
1		Medical
3		Other
4	Eviction	Temporary shelter
2		Fire
1		Transportation
1		Poor housing conds.
2	Fire	Eviction
2		Other living arr.
1		Temporary shelter
1		Poor housing conds.
1	Poor housing conds.	Fire
1		Eviction
1		Dirty/smelly
3	Needs food	Temporary shelter
1		Wandering/lost
3	Victimization	Transportation
1		Temporary shelter
1		Dirty/smelly
2	Medical care/eval	Temporary shelter
1		Wandering/lost

2 1 1	Other living arr.	Fire Temporary shelter Transportation
1 1 1 1	Dirty/smelly	Housing conditions Victimization Needs assessment Other
1	Needs assessment	Dirty/smelly
1	No utilities	Transportation
4 3 1	Other	Temporary shelter Wanderer Dirty/smelly

Table A4 Demographic Data for Sample Drawn in 1988

Sample*	Whole Sample	Type A	Type B1	Type B2	type B3
Characteristics	n=475	n=287	n=129	n=39	n=21
Modal age group	60-64	65-69	70-74	75-79	70-74
Sex (percent female)	58.5	60.4	53.2	60.5	61.9
Race (percent white)	44.7	37.9	53.3	57.7	50.0
Major source of last referral	CPD	CPD	CPD	CPD	CPD
Year of last referral					
% 1985	23.9	21.3	25.2	39.5	23.8
% 1986	27.7	30.3	22.8	28.9	19.0
% 1987	27.7	28.9	25.2	18.4	42.9
% 1988	20.7	19.5	26.8	13.2	14.3
Number of ES contacts					
1	77.2	85.0	64.3	78.9	61.9
2	12.0	10.5	17.1	10.5	4.8
3-5	6.3	3.1	10.9	7.9	19.1
6-10	3.2	1.3	5.5	2.6	14.3
11-15	0.0	0.0	0.0	0.0	0.0
over 15	0.6	0.0	2.4	0.0	0.0
Living arrangement at referral:					
Own home or apartment	79.8	88.5	51.2	94.7	76.2
Not known	12.2	9.4	22.5	2.6	0.0
Streets or shelter	10.6	1.2	29.8	2.6	14.3
SRO	3.8	3.8	4.0	0.0	4.8
Nursing Home	3.6	4.2	3.2	0.0	0.0
Relative's home	2.2	2.3	2.4	0.0	0.0
Primary problem at last referral:					
Fire	18.9	27.2	8.5	2.6	0.0
Wanderer/confused/lost	18.9	23.0	17.6	0.0	4.8
Needs Transportation	13.5	17.8	8.5	0.0	4.3
Needs temporary shelter	12.6	0.0	45.7	0.0	4.8
Other	11.7	14.6	7.0	5.2	14.4
Run down housing	6.7	0.0	0.0	57.9	47.6
Needs assessment of situation and needs	4.8	6.6	2.3	2.6	0.0
Victimization	3.2	4.5	1.6	0.0	0.0
Eviction	2.9	2.8	3.9	2.6	0.0
No utilities	2.9	0.0	0.0	26.3	19.0
Needs medical care or assessment	2.5	2.8	2.3	2.6	0.0
Needs other housing	.6	.3	1.6	0.0	0.0
Total number of problems:					
1	51.2	65.9	28.7	36.8	14.3
2	29.1	23.0	36.4	52.6	23.8
3	11.6	7.0	21.7	2.6	28.6
4	5.7	3.8	7.8	5.3	19.0
5 or more	1.9	0.0	3.9	2.6	14.3

* Type A cases had no record of need for temporary housing nor of poor housing conditions.
Type B1 had a record of need for temporary housing but not of poor housing conditions.
Type B2 had a record of poor housing conditions, but not of need for temporary housing.
Type B3 had a record of both poor housing conditions and need for temporary housing.

Table A5 Comparison of located Clients to Random Sample of Housing Related Cases

Variable	Sample^	Value	Statistic	p
Proportion female	All random	.557	z =	
	All located	.500	1.00	>.05
	Located,ES	.551	.99	>.05
Proportion white	All random	.548	z =	
	All located	.432	1.89	<.05*
	Located, ES	.447	1.44	>.05
proportion married	All random	.278	z =	
	All located	.170	1.00	>.05
	Located, ES	.183	1.09	>.05
proportion widowed	All random	.306	z =	
	All located	.223	0.98	>.05
	Located, ES	.283	0.24	>.05
proportion sep/div	All random	.139	z =	
	All located	.245	1.32	>.05
	Located, ES	.217	0.84	>.05
proportion single	All random	.278	z =	
	All located	.362	0.90	>.05
	Located, ES	.317	0.40	>.05
proportion in independent housing at last ES contact	All random	.563	z =	
	All located	.460	1.74	<.05*
	Located, ES	.600	1.55	>.05
proportion undomiciled at last ES contact	All random	.219	z =	
	All located	.175	1.05	>.05
	Located, ES	.232	0.23	>.05
proportion in SRO at last ES contact	All random	.038	z =	
	All located	.040	0.04	>.05
	Located, ES	.053	0.52	>.05
proportion in Nursing Home at last ES contact	All random	.022	z =	
	All located	.016	0.37	>.05
	Located, ES	.021	0.05	>.05

Variable	Sample	Value	Statistic	p
Mean age	All random	73.483	t =	
	All located	74.903	1.22	>.20
	Located, ES	74.295	0.72	>.20
Mean number of ES contacts	All random	2.356	t =	
	All located	6.203	2.83	<.01*
	Located, ES	4.061	2.56	<.02*
Mean number of problems identified	All random	2.223	t =	
	All located	2.062	1.02	>.20
	Located, ES	2.673	2.83	<.01*

^ N of All random = 188; N of All located = 134; N of Located ES = 98.

* Statistically significant at the .05 level.

Table A6 Comparison of Located to Non-located Subjects

Variable	Group	n	value	df	t	p
sex, % female	located	101	57.4	122	1.59	.114
	not loc	23	39.1			
Age, mean	located	94	74.4	50	-4.25	.000*
	not loc	21	84.0			
Race, % white	located	87	43.7	101	-0.01	.996
	not loc	16	43.8			
Mean # ref'ls	located	97	3.8	118	0.52	.604
	not loc	23	3.0			
% Married	located	64	20.3	64	-1.00	.319
	not loc	2	50.0			
% Widow	located	64	28.1	64	0.87	.387
	not loc	2	0.0			
% Sep/div	located	64	21.9	64	0.74	.464
	not loc	2	0.0			
% Single	located	64	29.7	64	-0.61	.545
	not loc	2	50.0			
Mean # prob	located	98	2.6	119	1.07	.288
	not loc	23	2.3			
% alive	located	82	79.5	82	1.95	.055
	not loc	2	0.0			
% undomi	located	83	23.3	105	-2.04	.044
	not loc	24	47.0			

* statistically significant at the .05 level

Table A7 Characteristics of Shelter user (ES Sample)

Variable	Group	Value	n	df	t	p
Sex, % female	use	45.3	53	101	1.92	.057
	no use	64.0	50			
Race, % white	use	47.8	46	85	-1.29	.200
	no use	34.2	41			
Mean # ref'ls	use	6.43	51	99	-4.11	.000*
	no use	1.20	50			
mean,# problem	use	2.94	51	99	-2.84	.006*
	no use	2.20	50			
% got formal help	use	39.1	29	50	-1.93	.063
	no use	65.5	23			
% got informal help	use	64.3	28	50	0.49	.624
	no use	70.8	24			
Mean OARS score	use	17.5	23	39	-0.80	.428
	no use	16.9	18			
Mean dementia score	use	2.05	22	39	-0.79	.434
	no use	1.79	19			

* statistially significant at .05 level

Table A8 Homelessness by Interviewed Group

	Housing Cond's.	Shelter Need	SRO	
Never homeless	27	[illegible]	21	55
Previously homeless	10	[illegible]	5	50
Currently homeless		[illegible]		7
	37	49	26	112

Table A9 Duration of Homelessness by Times Homeless

	Short term	Long term	Unclear	
One time	32	3	1	36
Repeated	7	12	1	20
Repeated, unconf'd.	2	1	1	4
unknown		1		1
	41	17	3	61

Chi^2=24.33, df=6, p=.0005

Table A10 Demographics by Whether Ever Homeless

Variable	Group	n	Value	df	t	p
Age, mean	Never Ever	55 57	75.2 74.2	110	.57	.568
Sex, % female	Never Ever	55 57	49.1 49.1	110	.00	.997
Race, % white	Never Ever	54 50	43.1 46.0	99	-.29	.775
% Married	Never Ever	41 38	14.6 13.2	77	.19	.852
% widowed	Never Ever	41 38	24.4 21.0	77	.35	.728
% sep/divorced	Never Ever	41 38	22.0 29.0	77	-.71	.481
% single	Never Ever	41 38	39.0 36.8	77	.20	.844

Table A11 Demographic Comparison by whether repeater or one-time homeless

Variable	Group	n	Value	df	t	p
Age, mean	Repeat	20	73.2	53	.68	.568
	Once	35	74.9			
Sex, % female	Repeat	20	35.0	53	1.38	.498
	Once	35	54.3			
Race, % white	Repeat	19	26.3	46	2.01	.050*
	Once	29	55.2			
married	Repeat	14	7.1	34	.59	.559
	Once	22	13.6			
% widowed	Repeat	14	21.4	34	.38	.703
	Once	22	27.3			
% sep/divorced	Repeat	14	35.7	34	-0.83	.411
	Once	22	22.7			
% single	Repeat	14	35.7	34	.04	.970
	Once	22	36.4			

Table A12 Contributing Factors (Other problems)

Variable	Group	n	Value	df	t	p
Alcohol/drugs	never	54	40.7	88	-1.24	.217
	ever	57	84.2			
Psych or dementia	never	51	25.5	102	-2.74	.007*
	ever	53	50.9			
Health/handicap	never	54	44.4	75	.23	.818
	ever	57	40.4			
Eviction	never	30	16.7	65	-6.27	.000*
	ever	37	78.4			
Fire	never	33	15.2	83	-0.03	.977
	ever	52	15.4			
Abuse	never	54	59.3	109	-0.47	.638
	ever	37	79.0			
Other	never	33	30.3	83	-0.08	.939
	ever	52	32.7			

Table A13 Support Network by whether ever homeless

Variable	Group	n	Value	df	t	p
% who have children	Never	55	70.9	110	-0.15	.883
	Ever	57	70.2			
Mean # of children	Never	55	3.60	110	.08	.993
	Ever	57	3.70			
Mean # involved children	Never	55	2.53	110	-1.41	.160
	Ever	57	3.49			
Mean # informal helpers	Never	38	73.7	78	.19	.850
	Ever	42	71.4			
% with formal help	Never	38	44.7	77	-1.46	.149
	Ever	41	63.4			
mean aloneness score	Never	37	2.68	81	.01	.991
	Ever	49	2.67			

Table A14 Comparison of Younger to Older SRO Clients

Variable	Age<65 n=5	Age 65+ n=22	chi^2	df	p
# with formal help	2	7	.23	1	.60
# with informal help	2	16	.21	1	.60
# with involved children	1	1	.18	1	.65
median income	542	517	23.7	22	.36
Mean ES score	3.0	3.1	1.23	4	.97
Mean SR score	2.4	2.6	2.26	4	.69
Mean MH score	2.2	2.6	3.43	3	.33
Mean PH score	3.4	3.3	1.44	4	.84
Mean ADL score	2.0	2.2	1.11	3	.78
Mean Total OARS score	13.0	13.7	13.11	10	.33
Mean Dementia score	1.0	1.0	0.00	1	1.00

Table A15 Stability of last living arrangement

	Never	Ever
Stable	41	27
Change Immanent	3	9
Change forseeable	8	12
not applicable		1
not known	3	8

chi2 = 9.92, df=4, p=.04

Table A16 Stability of living arrangments over time

	Never	Ever
Past and current	36	11
Current only	3	3
Past only	6	14
Chronic Instability		8
Not clear, unknown	10	11

Chi2 = 30.35, df=4, p=.0000